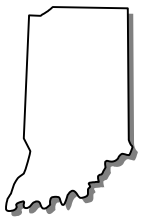
Client Services Unit



INDIANA HEALTH COVERAGE PROGRAMS

Teleprocessing Users Guide-Eligibility

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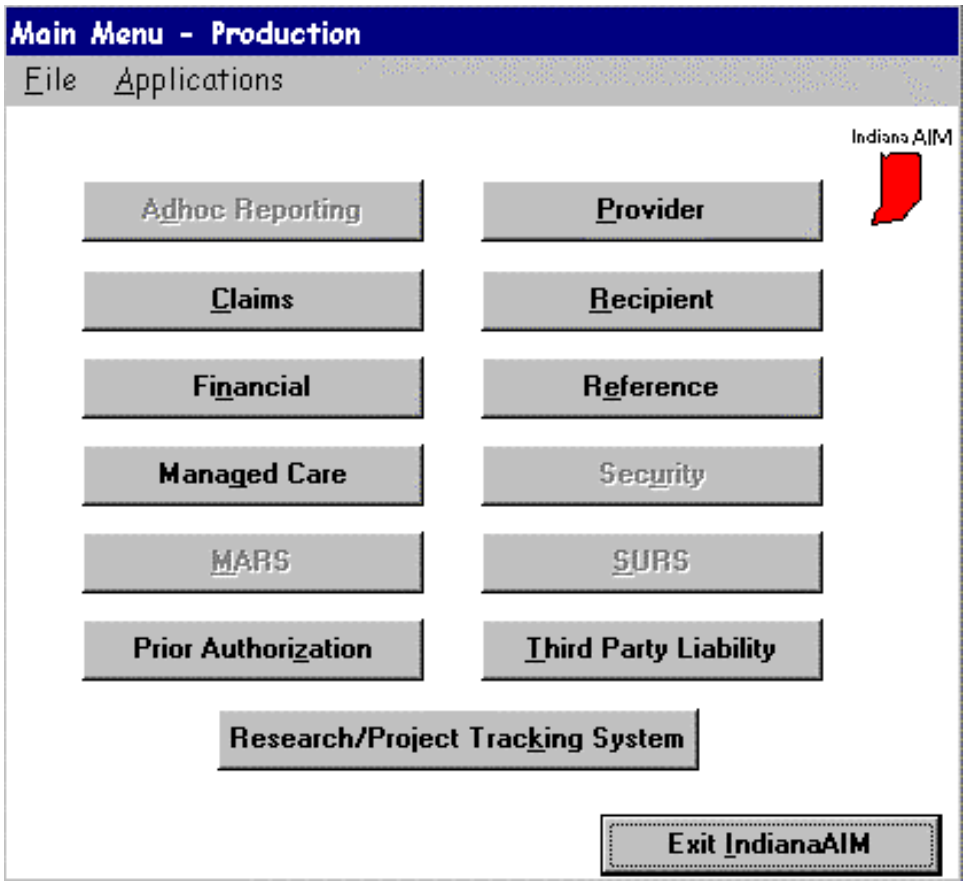

Figure 1.1 – Main Menu Window

File	Applications
Exit Indiana*AIM*	Adhoc Reporting
	Claims
	Financial
	Managed Care
	MARS
	Prior Authorization
	Provider
	Member
	Reference
	Security
	SURS
	Third Party Liability
	System Parms
	Research/Project Tracking System

Figure 1.2 - Main Menu Window Menu Tree

Figure 1.2 is an illustration of a menu tree for the Main Menu. The menu titles on this illustration reflect the overall menu commands and window options on the Main Menu.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File and Applications have the same functions on all the windows.

Menu Selection: File

This command allows the user to exit the Indiana*AIM* application.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Section 2: Member Search Window

Introduction

The Member Search window is the initial window viewed upon entry into the Member application. This window allows the user to access member information by selecting a SEARCH BY criteria. Once the search criterion is selected and the values entered for the search, the Member Base Window is displayed.

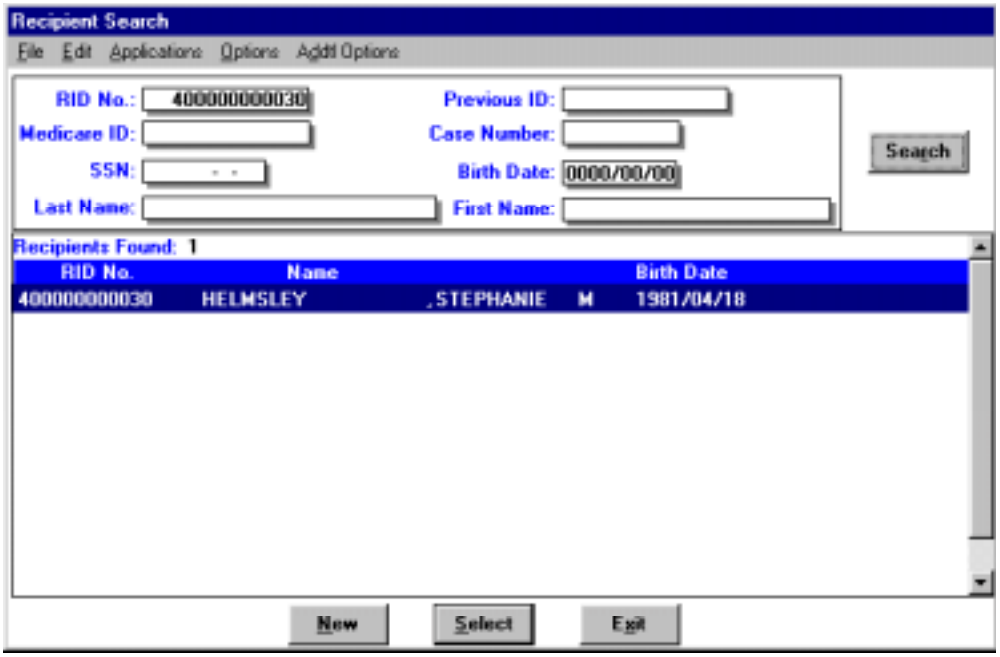

Figure 2.1 – Member Search Window

File	Edit	Applications	Options		Addt'l Options
Print	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Exit	Paste	Claims	CSHCS		TPL Search/Resource
Audit	Cut	Financial	Eligibility	Standard	
Exit Indiana*AIM*		Managed Care		Replaced	
		MARS	EOMB Request		
		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 2.2 - Member Search Window Menu Tree

Figure 2.2 is an illustration of a menu tree for the Member Search Window. All menus appear in single-line boxes. The menu titles on

this illustration reflect the overall menu commands and window options on the Member Search Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT.**

Menu selections File and Applications, and Options have the same functions on all the member windows.

Menu Selection: File

These are commands that allow the user to move around Indiana*AIM*:

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to the main menu

Audit – Allows the user to access the online audit trail windows

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Edit

This menu command allows the user to make adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem

Base – Allows the user to access the Member Base Screen for the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access the standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers.
- Missed Apzpointment Codes.
- Periodicity Schedules.
- Member Abnormalities Member Notices.
- Member Screenings.

ID Cards – Allows the user to access the ID Card Window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization.

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override, Part B Billing
- Part A Billing

- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions.

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs or addresses.

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *SEARCH*

Description – Click button to initiate a search

Format – Search parameters are the following:

- RID No.
- Medicare ID
- Last name only
- First three characters of the first name and last name
- Last name and DOB
- SSN
- Case number
- Previous ID
- First three characters of the previous first name and last name

Features – None

Edits – 91056-Please enter at least one search field

To Correct – An entry is required to search for a member. Type in the RID No. or choose an alternative search option.

Field Name: *RID NO*

Description – The member identification number assigned by ICES

Format – 12 numeric characters

Features – None

Edits – 4003 – ID must be 12 characters!

To Correct – Verify entry. The RID No. must be 12 characters

91056 – Please enter at least one search field

To Correct – An entry is required in order to search for a member. Key in the RID NO or choose an alternative search option

91007 – Data must be numeric!

To Correct – Enter a 12 numeric character value

91024 – No match found for RID No.!

To Correct – Enter a valid RID No. There was not a match on the member file for the ID keyed

Field Name: *MEDICARE ID*

Description – Search by member's Medicare number

Format – Twelve alphanumeric characters

Features – None

Edits – 4003 – ID must be twelve characters!

To Correct – Verify entry. The Medicare ID must be twelve characters long

91006 – Field is required!

To Correct – An entry is required in order to search for a member. Key in the ID or choose an alternative search option

91024 – No match found for Medicare ID!

To Correct – Enter a valid Medicare ID. There was not a match on the member file for the ID keyed

91034 – Medicare ID must contain only A-Z, 0-9!

To Correct – Verify entry. The Medicare ID must only contain the letters A-Z, or numbers 0-9

Field Name*: SOCIAL SECURITY NUMBER*

Description – Search by member's social security number

Format – Nine numeric characters

Features – None

Edits – 4005-SSN must be in numeric form

To Correct – Verify entry. Social security number must be nine numeric characters

91024 – No Match Found!

To Correct – Verify entry and rekey.

91007 – SSN Data must be numeric.

To Correct – Verify entry. Social security number must be nine numeric characters.

Field Name: *LAST NAME*

Description – Search by member's last name

Format – 15 alphanumeric characters

Features – None

Edits – 91024 – No Match Found!

To Correct – Verify entry and rekey

Field Name: *FIRST AND LAST NAME*

Description – Search by member's first and last name

Format – 28 alphanumeric characters

Features – None

Edits – 91024 – No Match Found!

To Correct – Verify entry and rekey

Field Name: *LAST NAME AND DOB*

Description – Search by member's last name and date of birth

Format – 23 alphanumeric characters

Features – None

Edits – 91024 – No Match Found!

To Correct – Verify entry and rekey. There was not a match on the member file for the search keyed.

91002 – Date must be in numeric form.

To Correct – Verify entry and rekey.

91001 – Invalid Date (CCYYMMDD).

To Correct – Verify entry and rekey. Date must be in CCYYMMDD format.

Field Name: *CASE NUMBER*

Description – Search by member's case number

Format – 10 numeric characters

Features – None

Edits – 4004 – Case number must be in numeric form.

To Correct – Verify entry and rekey.

Field Name: *PREVIOUS ID*

Description – Search by member's previous RID number or PCN number

Format – 12 numeric characters

Features – None

Edits – 4003 – ID must be 12 characters!

To Correct – Verify entry. The previous ID must be 12 characters.

91056 – Please enter at least one search field.

To Correct – An entry is required to search for a member. Key in the previous RID No., the previous PCN, or choose an alternative search option.

91007 – Data must be numeric!

To Correct – Enter a 12 character numeric value.

91024 – No match found!

To Correct – Enter a valid RID No. There was not a match on the member file for the ID typed.

Other Messages

None

System Information

PBL – RECIP01_PBL

Window – W_RE_SEARCH

Data Windows – DW_RE_SELECT_CASE

DW_RE_SELECT_HIB

DW_RE_SELECT_ID

DW_RE_SELECT_NAME

DW_RE_SELECT_NAME_2

DW_RE_SELECT_NAME_DOB

DW_RE_SELECT_PCN

DW_RE_SELECT_PRV_NAME

DW_RE_SELECT_SSN

System Features

The Member Search window no longer has a drop-down list box for search options. The user can type any of the fields to complete the search. The default is the RID No. If there is a number in the RID field and data in the last name field, the search will be conducted on the RID No. Once the search criterion is placed in the appropriate field, the search is activated by clicking **Search**. If multiple members have met the criteria, the vertical scroll bar can be used to view the entire list of members. Other information is provided to identify members (including RID No., name, birth date, and social security

number) depending on the search criteria used. For example, if the search criteria is RID No., only the member name and date of birth are necessary to completely identify the member. Once member is identified, the user can select the member by double-clicking on the highlighted name or by clicking **Select**. Click **New** to display a blank Member Base window in which a new member can be added.

Section 3: Member Base Window

Introduction

This window contains basic information about a member, including name and address. A member is a person who receives the Indiana Health Coverage Programs (IHCP) benefits. Only authorized users with update privileges have the capability to add new information or modify existing data. The Member Base window is accessed through the Member Search window by typing a valid value for the search criteria. Once the search criterion is met, the Member Base window displays. All other Member windows are available options from the Member Base window.

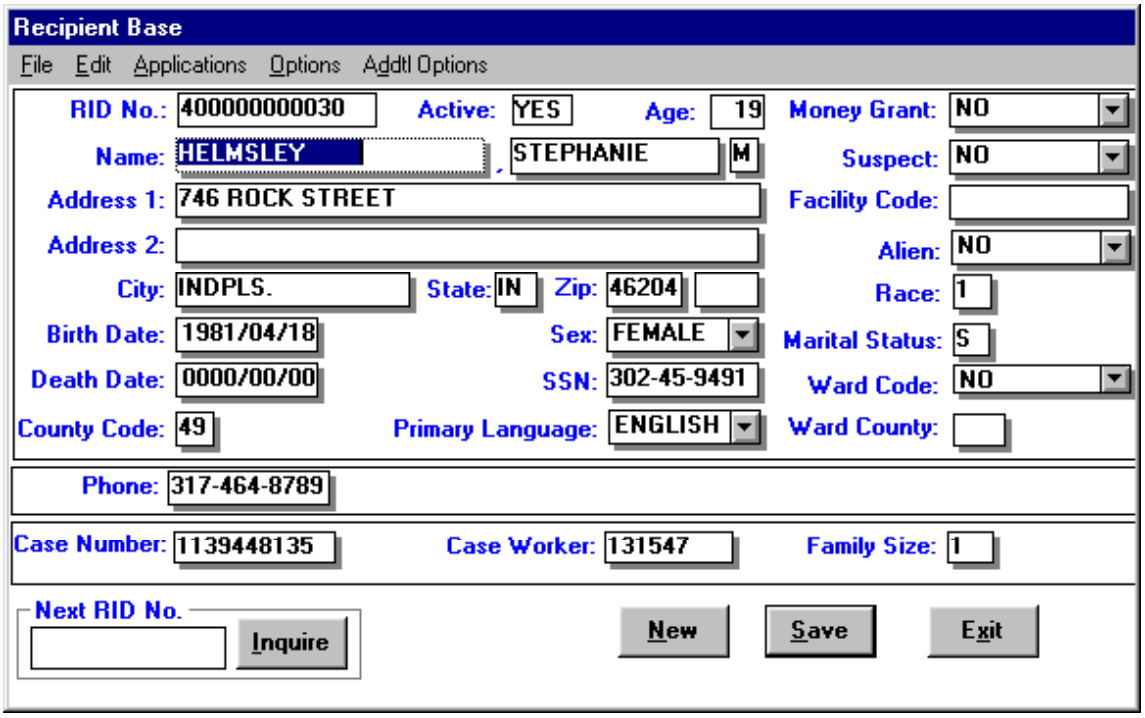

Figure 3.1 – Member Base Window

File	Edit	Applications	Options	
			Base	**Standard**
Print	Copy	Adhoc Reporting		
Exit	Paste	Claims	CSHCS	SUR EOMB Rqst
Audit	Cut	Financial	Eligibility-	TPL Search/Resource
Exit Indiana*AIM*		Managed Care		Replaced
		MARS	EOMB Request:	
		Prior Authorization	EPSDT	Abnormalities w/modifiers
		Provider		Abnormalities w/out modifiers
		Member		Missed appointment schedules
		Reference		Periodicity Schedules
		Security		Accelerated Schd 2 to 6
		SURS		Accelerated Schd 7 to 17
		Third Party Liability		Accelerated Schd 18 and over
		System Parms		Regular Screening
		Research/Project Tracking System		Regular Supplement
				Recip abnormalities
				Recip notices
				Recip screenings
			ID Cards	Lockin Base
			Lock-in-	Lockin Base
				Lock Notification
				Lock Prov Notification
				Lock Prov End Notification
				Lock Utilization
			LOC	
			Medicare-	Billing A Mismatches
				Billing B Mismatches
				Buyin Coverage
				Dual Aid Eligibility
				Medicare Coverage
				Override
				Part A Billing
				Part B Billing
				Premium 150
				Premium S15
				Premium S15 Exceptions
				Premium 150 Exceptions
			Patient Liab	Premium 150 Exceptions
			Potential MC Recip	Addresses
			Previous-	Addresses
				Names
				PCNs
			PMP Assignment	PCNs
			Recip Mother RID	
			Redetermination Date	
			Search	
			Spenddown	
			590 Search	
			Suspended ICES Dupe	
			Link History	
			Mgd Care Rate Cell	

Figure 3.2 - Member Base Window Menu Tree

Figure 3.2 is an illustration of a menu tree for the Member Base Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Base Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to add a new member, print the window, exit the Member Base window and save data in the Member Base window.

New – Opens the Member Base window.

Save – Saves entered information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*.

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem

Base – Allows the user to access the Member Base Screen for the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access the standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers.
- Missed Appointment Codes.
- Periodicity Schedules.
- Member Abnormalities Member Notices.
- Member Screenings.

ID Cards – Allows the user to access the ID Card Window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization.

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override, Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions.

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs or addresses.

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO*

Description – The member identification number assigned by ICES

Format – 12 numeric characters

Features – None

Edits – None

To Correct – N/a

Field Name: *MARITAL STATUS*

Description –Member's marital status

Format – One alphabetic character. Valid values are as follows:

- *S* – Single
- *T* – Separated
- *D* – Divorced
- *W* – Widowed

- *X* – Unknown
- *M* – Married

Features – Pop-up window

Double-click to select a valid marital status.

Edits – 91007-Marital Status Code Data must be alphabetic!

To Correct: Enter a one alphabetic character marital status code.

91011 – Marital status record not found - please try again!

To Correct – Enter valid one alphabetic character marital status code.

Field Name: *AGE*

Description – Member's age. This is calculated from the birth date to the current date.

Format – Three numeric characters

Features – None

Edits – None

To Correct – N/a

Field Name: *MONEY GRANT*

Description – Identifies whether the member does or does not receive a money grant

Format – One alphabetic character. (Y – Yes, N – No)

Features – Drop-down list box

Edits – None

To Correct – N/a

Field Name: *NAME*

*Description*s – Member's first name, last name, and middle initial

Format – Last name - 15 alphanumeric characters

First name - 13 alphanumeric characters

Middle Initial - one alphanumeric character

Features – None

Edits – 91006 – Last Name Field is required!

To Correct – Enter a new name

4117 – Field must have at least one alpha character!

To Correct – Enter alpha characters in the new name field

Field Name: *ADDRESS 1*

Description – Member address line 1

Format – 30 alphanumeric characters

Features – None

Edits – 91006 – Address 1 Field is required!

To Correct – Enter the member's address

4117 – Address 1 Field must have at least one non-numeric character!

To Correct – Enter a valid address with at least one alphanumeric character

Field Name: *ADDRESS 2*

Description – Member address line 2

Format – 30 alphanumeric characters

Features – None

Edits – None

To Correct – N/a

Field Name: *ALIEN*

Description – Indicates if the member is an alien (foreign) and if so, the status

Format – Seven alphabetic characters. Valid values are as follows:

- *I* – Illegal

- *L* – Legal
- *N* – No

Features – Drop-down list box

Edits – None

To Correct – N/a

Field Name: *CITY*

Description – Member's city

Format – 15 alphanumeric characters

Features – None

Edits – 4117 – Field must have at least one alphabetic character!

To Correct – Verify entry and rekey

Field Name: *STATE*

Description – Member's state

Format – Two alphabetic characters. Valid values are displayed in Table 3.1.

Table 3.1 – State Codes

Code	State Name	Code	State Name
AK	Alaska	AL	Alabama
AR	Arkansas	AZ	Arizona
CA	California	CN	Connecticut
CO	Colorado	DE	Delaware
FL	Florida	GA	Georgia
HI	Hawaii	IA	Iowa
ID	Idaho	IL	Illinois
IN	Indiana	KS	Kansas
KY	Kentucky	LA	Louisiana
MA	Massachusetts	MD	Maryland
ME	Maine	NH	New Hampshire
NJ	New Jersey	MN	New Mexico
NV	Nevada	NY	New York
OH	Ohio	OK	Oklahoma
MN	Minnesota	MO	Missouri
MS	Mississippi	MT	Montana
NC	North Carolina	ND	North Dakota
NE	Nebraska	OR	Oregon
PA	Pennsylvania	RI	Rhode Island
SC	South Carolina	SD	South Dakota
TN	Tennessee	TX	Texas
UT	Utah	VA	Virginia
WA	Washington	WI	Wisconsin
WV	West Virginia	WY	Wyoming

Features – Pop-up window

Edits – 4009 – Field must be two characters!

To Correct – Enter a two character state code.

91007 – State Data must be alphabetic!

To Correct – Enter a two character state code.

91011 – State code record not found!

To Correct – Enter a valid two character state code.

Field Name: *ZIP*

Description – Member's ZIP code

Format – Five initial numeric characters plus four numeric characters

Features – None

Edits – 4007 – ZIP code must be five characters!

To Correct – Enter a five numeric character in the ZIP code field.

91007 – ZIP code must be numeric!

To Correct – Enter a five numeric character in ZIP code field.

4008 – ZIP code four must be four characters.

To Correct – Enter a four numeric character in ZIP code four field.

Field Name: *BIRTH DATE*

Description – Member's date of birth

Format – Eight numeric characters (CCYY/MM/DD)

Features – None

Edits – 4006 – Death date must be greater than or equal to Birth date!

To Correct – Enter a death date greater than or equal to birth date.

4015 – Eligibility effective date must be greater than or equal to birth date!

To Correct – Enter an eligibility effective date greater than or equal to birth date.

91022 – Date cannot be greater than today's date!

To Correct – Enter a date less than or equal to today's date.

Field Name: *SEX*

Description – Member's sex

Format – One alphabetic character. Valid values are as follows:

M – Male

F – Female

Features – Drop-down list box

Edits – None

To Correct – N/a

Field Name: *SUSPECT*

Description – Indicates the member's file is being monitored by Program Integrity (PI) or the contractor for claim irregularity.

Format – One character alphabetic. (Y – Yes, N – No)

Features – Drop-down list box

Edits – None

To Correct – N/a

Field Name: *DEATH DATE*

Description – Member's death date

Format – Eight alphanumeric characters

Features – None

Edits – 4013 – Death date must be greater than or equal to eligibility end date!

To Correct – Enter a death date greater than or equal to eligibility end date.

4014 – Death date must be greater than or equal to eligibility effective date!

To Correct – Verify dates and rekey.

91022 – Date cannot be greater than Today's Date!

To Correct – Enter a date less than or equal to today's date.

Field Name: *SSN*

Description – Member's social security number

Format – Nine numeric characters

Features – None

Edits – 4005 – SSN must be nine numeric characters!

To Correct – Enter a nine character social security number code.

4115 – SSN is a duplicate!

To Correct – Research the existing SSN through the search option.

91007 – Data must be numeric!

To Correct – Enter a nine digit social security number.

Field Name: *RACE*

Description –Member's race

Format – One numeric character. Valid values are as follows:

1 – White

2 – Black

3 – Asian

4 – Indian

5 – Hispanic

6 – Other

Features – Pop-up window

Edits – 91007 – Race code data must be numeric!

To Correct – Enter numeric data.

91009 – System database read error!

To Correct – Contact EDS systems engineer.

91011 – Race code record not found - please try again!

To Correct – Enter a valid race code.

Field Name: *PRIMARY LANGUAGE*

Description – Member's primary speaking language

Format – One alphabetic character. Valid values are as follows:

E – English

S – Spanish

Features – Drop-down list box

Edits – None

To Correct – N/a

Field Name: *FACILITY CODE*

Description –Member's facility code if the member is enrolled in the 590 program

Format – Three alphanumeric characters

Features – Pop-up window features the facility code values displayed in Table 3.2.

Table 3.2 – Facility Codes

Code	Facility Name
ACC	ATTERBURY CORRECTIONAL CENTER
BLW	BLOOMINGTON WORK RELEASE CENTER
BTC	BRANCHVILLE TRAINING CENTER
CCU	CENTRAL STATE CORRECTIONAL UNIT
CHW	CRAINE HOUSE WORK RELEASE CENTER
CIC	CORRECTIONAL INDUSTRIAL COMPLEX
COA	CENTRAL OFFICE ADMINISTRATION
COL	CHAIN O LAKES CORRECTIONAL UNIT
ESH	EVANSVILLE STATE HOSPITIAL
EVW	EVANSVILLE WORK RELEASE CENTER
FSD	FT WAYNE STATE DEV CTR
FWW	FORT WAYNE WORK RELEASE CENTER
GEN	GENERIC FACILITY

(Continued)

Table 3.2 – Facility Codes

Code	Facility Name
GTC	GLENVIEW TREATMENT CENTER
HYC	CLARK COUNTY CORRECTIONAL UNIT
IBS	INDIANA BOYS' SCHOOL
IGS	INDIANA GIRL'S SCHOOL
IMW	INDIANAPOLIS MEN'S WORK RELEASE CENTER
ISB	INDIANA SCHOOL FOR THE BLIND
ISC	INDIANA SOLDIERS AND SAILORS CHILDRENS HOME
ISD	INDIANA SCHOOL FOR THE DEAF
ISF	INDIANA STATE FARM
ISP	INDIANA STATE PRISON
ISR	INDIANA STATE REFORMATORY
IVH	INDIANA VERTERANS HOME
IWI	INDIANA WOMEN'S INTAKE
IWP	INDIANA WOMEN'S PRISON
IWW	INDIANAPOLIS WOMEN'S WORK RELEASE CENTER
IYC	INDIANA YOUTH CENTER
JCU	JOHNSON CORRECTIONAL UNIT
LCM	LARUE D. CARTER MEMORIAL HOSPITIAL
LCU	LAKESIDE CORRECTIONAL UNIT
LSH	LOGANSPORT STATE HOSPITIAL
MCC	MAXIMUM CONTROL COMPLEX
MCU	MADISON CORRECTIONAL UNIT
MSD	MUSCATATUCK STATE DEV
MSH	MADISON STATE HOSPITIAL
MYC	MEDARYVILLE CORRECTIONAL UNIT
NCS	NEW CASTLE STATE HOSPITAL
NIS	NORTHERN IN STATE DEV CTR
OTH	OTHER
P4A	EVANSVILLE DISTRICT OFFICE #4A
P4B	TERRE HAUTE DISTRICT OFFICE #4B
PD0	CENTRAL OFFICE PAROLE DISTRICT #0
PD2	FORT WAYNE DISTRICT OFFICE #2

(Continued)

Table 3.2 – Facility Codes

Code	Facility Name
PD3	INDIANAPOLIS DISTRICT OFFICE #3
PD5	COLUMBUS DISTRICT OFFICE #5
PD6	GARY DISTRICT OFFICE #6
PD7	NEW CASTLE DISTRICT OFFICE #7
PD8	SOUTH BEND DISTRICT OFFICE #8
RCU	RICHMOND CORRECTIONAL UNIT
RDC	RECEPTION DIAGNOSTIC CENTER
RSH	RICHMOND STATE HOSPITIAL
RSW	RIVERSIDE RESIDENTIAL CENTER
RTC	ROCKVILLE TRAINING CENTER
SBW	SOUTH BEND WORK RELEASE CENTER
SCD	SILVERCREST CHILDRENS DEVELOPMENT CENTER
SFW	SUMMIT FARM WORK RELEASE CENTER
WCC	WESTVILLE CORRECTIONAL CENTER
WPR	WESTVILLE PRE-RELEASE
WTU	WESTVILLE TRANSITION UNIT
WVC	WABASH VALLEY CORRECTIONAL INSTITUTION
WVW	WESTVILLE WORK RELEASE CENTER

Edits – None

To Correct – N/a

Field Name: *WARD CODE*

Description – Member's ward code

Format – Two numeric characters. Valid values are as follows:

NO

YES

CHINS

Court Order

Parent Term

Features – Pop-up window

Edits – None

To Correct – N/a

Field Name: *WARD COUNTY CODE*

Description – Member's county of ward

Format – Two numeric characters. Valid values are displayed in Table 3.3.

Table 3.3 – County Codes

Code	County Name	Code	County Name
01	ADAMS	36	JACKSON
02	ALLEN	37	JASPER
03	BARTHOLOMEW	38	JAY
04	BENTON	39	JEFFERSON
05	BLACKFORD	40	JENNINGS
06	BOONE	41	JOHNSON
07	BROWN	42	KNOX
08	CARROLL	43	KOSCIUSKO
09	CASS	44	LAGRANGE
10	CLARK	45	LAKE
11	CLAY	46	LAPORTE
12	CLINTON	47	LAWRENCE
13	CRAWFORD	48	MADISON
14	DAVIESS	49	MARION
15	DEARBORN	50	MARSHALL
16	DECATUR	51	MARTIN
17	DEKALB	52	MIAMI
18	DELAWARE	53	MONROE
19	DUBOIS	54	MONTGOMERY
20	ELKHART	55	MORGAN
21	FAYETTE	56	NEWTON
22	FLOYD	57	NOBLE

(Continued)

Table 3.3 – County Codes

Code	County Name	Code	County Name
23	FOUNTAIN	58	OHIO
24	FRANKLIN	59	ORANGE
25	FULTON	60	OWEN
26	GIBSON	61	PARKE
27	GRANT	62	PERRY
28	GREENE	63	PIKE
29	HAMILTON	64	PORTER
30	HANCOCK	65	POSEY
31	HARRISON	66	PULASKI
32	HENDRICKS	67	PUTNAM
33	HENRY	68	RANDOLPH
34	HOWARD	69	RIPLEY
35	HUNTINGTON	70	RUSH
72	SCOTT	83	VERMILLION
73	SHELBY	84	VIGO
74	SPENCER	85	WABASH
75	STARKE	86	WARREN
76	STEUBEN	87	WARRICK
71	ST. JOSEPH	88	WASHINGTON
77	SULLIVAN	89	WAYNE
78	SWITZERLAND	90	WELLS
79	TIPPECANOE	91	WHITE
80	TIPTON	92	WHITLEY
81	UNION	94	IFSSA
82	VANDERBURGH	99	OUT OF STATE

Features – Pop-up window

Edits – 91011 – County code record not found - Please try again!

To Correct – Enter two valid numeric characters.

91007 – County code data must be numeric!

To Correct – Enter numeric county code.

4120 – For IN state address, county code cannot be 99!

To Correct – Change the county code to an in-state county code or verify the state.

4119 – For OUT OF STATE address county must be 99!

To Correct – Change the county code to 99 if the state is not Indiana, or change the county code to a valid county code except 99.

Field Name: *FAMILY SIZE*

Description – Member's family size

Format – Two numeric characters

Features – None

Edits – 91007 – Family size data must be numeric

To Correct – N/a

Field Name: *COUNTY CODE*

Description – Member's county of residence

Format – Two numerics. Valid values are displayed in Table 3.4

Table 3.4- County Codes

Code	County Name	Code	County Name
01	ADAMS	36	JACKSON
02	ALLEN	37	JASPER
03	BARTHOLOMEW	38	JAY
04	BENTON	39	JEFFERSON
05	BLACKFORD	40	JENNINGS
06	BOONE	41	JOHNSON
07	BROWN	42	KNOX
08	CARROLL	43	KOSCIUSKO
09	CASS	44	LAGRANGE
10	CLARK	45	LAKE
11	CLAY	46	LAPORTE
12	CLINTON	47	LAWRENCE
13	CRAWFORD	48	MADISON

(Continued)

Table 3.4- County Codes

Code	County Name	Code	County Name
14	DAVIESS	49	MARION
15	DEARBORN	50	MARSHALL
16	DECATUR	51	MARTIN
17	DEKALB	52	MIAMI
18	DELAWARE	53	MONROE
19	DUBOIS	54	MONTGOMERY
20	ELKHART	55	MORGAN
21	FAYETTE	56	NEWTON
22	FLOYD	57	NOBLE
23	FOUNTAIN	58	OHIO
24	FRANKLIN	59	ORANGE
25	FULTON	60	OWEN
26	GIBSON	61	PARKE
27	GRANT	62	PERRY
28	GREENE	63	PIKE
29	HAMILTON	64	PORTER
30	HANCOCK	65	POSEY
31	HARRISON	66	PULASKI
32	HENDRICKS	67	PUTNAM
33	HENRY	68	RANDOLPH
34	HOWARD	69	RIPLEY
35	HUNTINGTON	70	RUSH
72	SCOTT	83	VERMILLION
73	SHELBY	84	VIGO
74	SPENCER	85	WABASH
75	STARKE	86	WARREN
76	STEUBEN	87	WARRICK
71	ST. JOSEPH	88	WASHINGTON
77	SULLIVAN	89	WAYNE
78	SWITZERLAND	90	WELLS
79	TIPPECANOE	91	WHITE
80	TIPTON	92	WHITLEY

(Continued)

Table 3.4- County Codes

Code	County Name	Code	County Name
81	UNION	94	IFSSA
82	VANDERBURGH	99	OUT OF STATE

Features – Pop-up window

Edits – 91011 – County code record not found - Please try again!

To Correct – Enter valid characters.

91007 – County code data must be numeric!

To Correct – Enter numeric county code.

91009 – System database read error!

To Correct – Contact EDS systems engineer.

4120 – For IN state address, county code cannot be 99!

To Correct – Change the county code to an in-state county code or verify the state.

4119 – For OUT OF STATE address county must be 99!

To Correct – Change the county code to 99 if the state is not Indiana, or change the county code to a valid county code except 99.

Field Name: *CASE NUMBER*

Description – The case number assigned to the member by the caseworker. Members in the same family may be assigned the same case number

Format – 10 numeric characters

Features – None

Edits – 4004 – Case number must be 10 numeric characters!

To Correct – Verify entry. Type 10 numeric characters.

91007 – Case Number Data must be numeric!

To Correct – Verify entry. Type 10 numeric characters.

Field Name: *CASE WORKER*

Description – Identifies the caseworker that determined the member's eligibility.

Format – Six alphanumeric characters

Features – Protected

Edits – 4010 – Caseworker must be six characters.

To Correct – Verify entry and rekey.

Field Name: *NEXT RID NO*

Description – Allows user to search for another member

Format – 12 numeric characters

Features – None

Edits – 4003 – Next RID Number must be 12 characters!

To Correct – Verify entry. The RID No. must be 12 characters.

91046 – New key is required!

To Correct – An entry is required to search for a member. Type the ID or choose an alternative search option.

91007 – Next RID No. Data must be numeric!

To Correct – Enter a numeric 12 character value.

4100 – No match found for RID No.!

To Correct – Enter a valid RID No. There was not a match on the member file for the ID typed.

Other Messages

None

System Information

PBL – RECIP01.PBL

Window – W_RE_BASE_1

Data Windows – DW_RE_BASE_1

DW_RE_BASE

DW_RE_CDE_RACE

DW_RE_COUNY

DW_RE_MARITAL_STATUS

System Features

Click **New** to display a blank window, allowing the user to add a new member. Click **Save** to save the new member and assign a RID No. or save changes made to the base window. Click **Exit** to return to the Member Search window.

Section 4: Member Eligibility Window

Introduction

IFSSA and EDS use the Member Eligibility window to view or update basic eligibility information on IHCP or other State program members. This window displays current and historical eligibility periods, IHCP aid categories and other state programs. The eligibility periods are used to perform basic member editing in claims processing. Only authorized users with update privileges have the capability to add new information or modify existing data. The Member Eligibility window can be accessed from the Member Base window by clicking **ELIGIBILITY** under **OPTIONS** on the toolbar or pressing **Alt+O** and **Shift+L**.

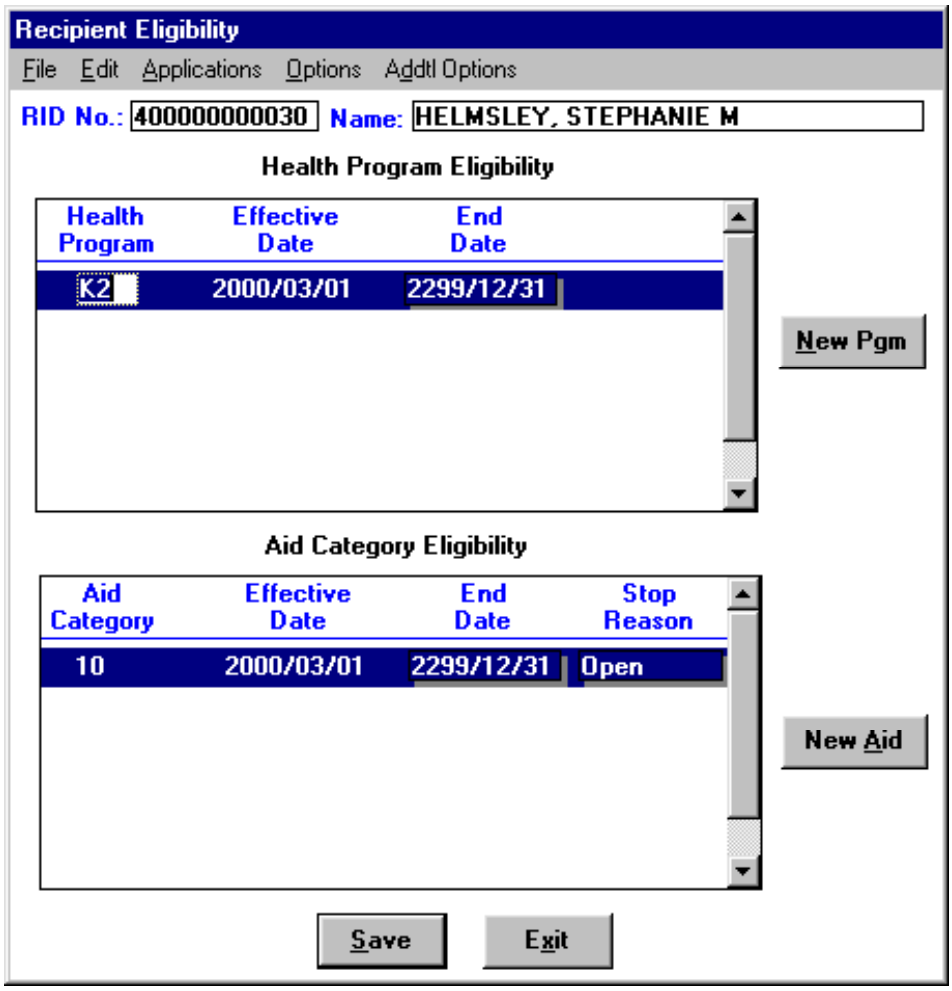

Figure 4.1 – Member Eligibility Window

File	Edit	Applications	Options		Addt'l Options
Print	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Exit	Paste	Claims	CSHCS		TPL Search/Resource
Audit	Cut	Financial	Eligibility	Standard	
Exit Indiana*AIM*		Managed Care		Replaced	
		MARS	EOMB Request		
		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 4.2 - Member Eligibility Window Menu Tree

Figure 4.2 is an illustration of a menu tree for the Member Eligibility Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Eligibility Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the eligibility window, exit the Member Eligibility window and exit the Indiana*AIM*.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to the previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*.

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem

Base – Allows the user to access the Member Base Screen for the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access the standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers.
- Missed Appointment Codes.
- Periodicity Schedules.
- Member Abnormalities Member Notices.
- Member Screenings.

ID Cards – Allows the user to access the ID Card Window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization.

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage

- Dual Aid Eligibility
- Medicare Coverage
- Override, Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions.

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs or addresses.

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO*

Description – The member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Full name of the member

Format – 29 alphabetic characters

Last name, first name, and middle initial

Features – Protected

Edits – None

To Correct – N/a

Field Name: *HEALTH PROGRAM*

Description – Identifies for which public health program the member is eligible.

Format – Two alphabetic characters. Valid values are the following:

MA – Medicaid

59 – 590

K2 – Hoosier Healthwise Package C

AR – ARCH

Features – Pop-up window

Double-click to see a pop-up window with valid health program codes

Select health program from the pop-up window, if desired

Edits – 4133 – Invalid Health Program!

To Correct – Verify health program. Use pop-up window for valid values.

91006 – Field is required!

To Correct – Verify entry. Entry is required.

Field Name: *EFFECTIVE DATE*

Description – The date that the IHCP member becomes eligible for the corresponding aid category

Format – Eight numeric characters (CCYYMMDD)

Features – None

Edits – 4011 – Effective date must be less than or equal to the end date!

To Correct – Verify date and date format and rekey.

4014 – Death date must be greater than or equal to eligibility effective date!

To Correct – Verify date and date format and rekey.

4015 – Eligibility date must be greater than or equal to birth date!

To Correct – Verify date and date format and rekey.

91001 – Invalid date (MMDDCCYY)!

To Correct – Verify date and format (CCYY/MM/DD).

91002 – Date must be numeric!

To Correct – Verify entry or rekey date as CCYY/MM/DD.

91003 – Date is required!

To Correct – Enter date in CCYY/MM/DD format.

91022 – Date cannot be greater than today's date!

To Correct – Verify entry and rekey date in CCYY/MM/DD format.

91030 – Date segments may not overlap!

To Correct – Verify date and rekey.

Field Name: *END DATE*

Description – End date of the member's eligibility

Format – Eight numeric characters (CCYY/MM/DD)

Features – None

Edits – 4013 – Death date must be greater than or equal to eligibility end date!

To Correct – Verify entry and rekey date in CCYY/MM/DD format.

4019 – Eligibility end date required w/stop reason code!

To Correct – Verify entry and rekey date in CCYY/MM/DD format.

4020 – Open-ended elig required w/stop reason None!

To Correct – Correct date or add stop reason.

91001 – Invalid Date (MMDDCCYY)!

To Correct – Verify entry and rekey date in CCYY/MM/DD format.

91002 – Date must be numeric!

To Correct – Verify entry and rekey date in CCYY/MM/DD format.

91022-Date cannot be greater than today's date!

To Correct – Verify entry and rekey date in CCYY/MM/DD format.

Field Name: *AID CATEGORY*

Description – Determines the IHCP benefits that the member can receive during the specified eligibility period

Format – One or two character alphanumeric. Valid values are displayed in Table 4.1.

Table 4.1 – Aid Categories

Public Health Program	Aid Category	Description	AVR Program/Benefit Package
MA	1	Children younger than 19 years old who meet TANF income standards	HH – Package A – Standard Plan
MA	2	Children ages 6 – 19 under 100 percent FPL	HH – Package A – Standard Plan
MA	3	Wards not IVE eligible under 18	HH – Package A – Standard Plan
MA	4	Title IVE foster children under 18	HH – Package A – Standard Plan
AR	5	ARCH for aged	Traditional Medicaid
AR	6	ARCH for blind	Traditional Medicaid
AR	7	ARCH for disabled	Traditional Medicaid
MA	8	Children Receiving Adoption Assistance	HH – Package A – Standard Plan
MA	9	Children age 1 – 19, up to 150 percent poverty	HH – Package A – Standard Plan
MA 10 (K2)	10	Hoosier Healthwise – Package C – Children's Plan	HH – Package C – Children's Health Insurance Plan
MA	A	Aged	Traditional Medicaid
MA	B	Blind	Traditional Medicaid
MA	C	Low income families	HH – Package A – Standard Plan
MA	D	Disabled	Traditional Medicaid
MA	E	Extended eligibility for pregnant women	HH – Package B – Pregnant Women
MA	F	Transitional medical assistance	HH – Package A – Standard Plan

(Continued)

Table 4.1 – Aid Categories

Public Health Program	Aid Category	Description	AVR Program/Benefit Package
MA	G	Qualified Disabled Working Individual (QDWI)	NOT eligible
MA	H	Ineligible for AFDC due to deemed income	HH – Package A – Standard Plan
MA	I	Qualified Individual – 1	NOT eligible
MA	J	Specified Low Income Medicare Beneficiary (SLMB)	NOT eligible
MA	K	Qualified Individual – 2	NOT eligible
MA	L	Qualified Medicare Beneficiary (QMB)	Traditional Medicaid
MA	M	Pregnancy – Full coverage	HH – Package A – Standard Plan
MA	N	Pregnancy – Related coverage	HH – Package B – Pregnant Women
MA	O	Children younger than 21 years old in inpatient psych facility	HH – Package A – Standard Plan
MA	P	No longer used	N/A
MA	Q	Refugee Medical Assistance (RMA)	Traditional Medicaid
MA	R	Room and Board Assistance (RBA)	Traditional Medicaid
MA	S	Ineligible for AFDC due to sibling income	HH – Package A – Standard Plan
MA	T	Children age 18, 19, 20 living with a specified relative	HH – Package A – Standard Plan
MA	U	Ineligible for TANF due to SSI payments	HH – Package A – Standard Plan
MA	X	Newborn – infants born to IHCP members	HH – Package A – Standard Plan
MA	Y	Children younger than one year old under 150 percent FPL	HH – Package A – Standard Plan
MA	Z	Children ages 1-5 under 133 percent FPL	HH – Package A – Standard Plan
MA	1P	Refugee children younger than 19 years old who meet AFDC income standards	HH – Package A – Standard Plan
MA	2P	Refugee children ages 6-19 under 100 percent FPL	HH – Package A – Standard Plan

(Continued)

Table 4.1 – Aid Categories

Public Health Program	Aid Category	Description	AVR Program/Benefit Package
MA	3P	Refugee wards not IVE eligible younger than 18 years old	HH – Package A – Standard Plan
MA	4P	Refugee Title IVE foster children younger than 18 years old	HH – Package A – Standard Plan
MA	5P	ARCH for aged, refugee	Traditional Medicaid
MA	6P	ARCH for blind, refugee	Traditional Medicaid
MA	7P	ARCH for disable, refugee	Traditional Medicaid
MA	8P	Refugee children receiving adoption assistance	HH – Package A – Standard Plan
MA	AP	Aged, refugee	Traditional Medicaid
MA	BP	Blind, refugee	Traditional Medicaid
MA	CP	Refugee – Low income families	HH – Package A – Standard Plan
MA	DP	Disabled, refugee	Traditional Medicaid
MA	FP	Refugee – Transitional medical assistance	HH – Package A – Standard Plan
MA	GP	Refugee – Qualified Disabled Working Individual (QDWI)	HH – Package A – Standard Plan
MA	HP	Refugee ineligible for AFDC due to deemed income	HH – Package A – Standard Plan
MA	LP	Refugee – Qualified Medicare Beneficiary (QMB)	Traditional Medicaid
MA	MP	Refugee pregnancy – Full coverage	HH – Package A – Standard Plan
MA	NP	Refugee pregnancy – Related coverage	HH – Package A – Standard Plan
MA	OP	Refugee children younger than 21 years old in inpatient psych facility	Traditional Medicaid
MA	PP	No longer used	N/A
MA	RP	Refugee Room and Board (RBA)	Traditional Medicaid
MA	SP	Refugee ineligible for AFDC due to sibling income	HH – Package A – Standard Plan
MA	TP	Refugee children age 18, 19, 20 living with a specified relative	HH – Package A – Standard Plan
MA	UP	Refugee ineligible for TANF die to SSI payments	HH – Package A – Standard Plan

(Continued)

Table 4.1 – Aid Categories

Public Health Program	Aid Category	Description	AVR Program/Benefit Package
MA	XP	Newborn – infants born to refugee members	HH – Package A – Standard Plan
MA	YP	Refugee children younger than one year old under 150 percent FPL	HH – Package A – Standard Plan
MA	ZP	Refugee children ages 1-5 under 133 percent FPL	HH – Package A – Standard Plan

Features – Pop-up window

Double-click to see pop-up window with valid aid category codes.

Select aid category from the pop-up window, if desired.

Edits – 4128 – Invalid aid category!

To Correct – Verify and enter a valid aid category.

91006 – Field is required!

To Correct – Select a valid value from the pop-up window.

Field Name: *EFFECTIVE DATE*

Description – Date that the IHCP member becomes eligible for the corresponding aid category

Format – Eight numeric character (CCYY/MM/DD)

Features – None

Edits – 4011 – Effective date must be less than or equal to the end date!

To Correct –Verify date and date format and rekey.

4014 – Death date must be greater than or equal to eligibility effective date!

To Correct –Verify date and date format and rekey.

4015 – Eligibility date must be greater than or equal to birth date!

To Correct –Verify date and date format and rekey.

30001 – User not authorized to update data!

To Correct –Verify for correct logon id.

91001-Invalid Date (MMDDCCYY)!

To Correct –Verify date and date format (CCYY/MM/DD).

91002 – Date must be numeric!

To Correct –Verify entry and rekey date in CCYY/MM/DD format.

91003 – Date is required!

To Correct –Enter date in CCYY/MM/DD format.

91022 – Date cannot be greater than today's date!

To Correct –Verify entry and rekey date in CCYY/MM/DD format.

91030 – Date segments may not overlap!

To Correct –Verify date and rekey.

4130 – Aid category date must equal health program effective date!

To Correct –Verify date and rekey date that equals the health program.

Field Name: *END DATE*

Description – End date of the member's eligibility

Format – Eight numeric characters (CCYY/MM/DD)

Features – None

Edits – 4013 – Death date must be greater than or equal to eligibility end date!

To Correct –Verify entry and rekey date in CCYY/MM/DD format.

4019 – Eligibility end date required w/stop reason code!

To Correct –Verify entry and rekey date in CCYY/MM/DD format.

4131 – Aid category end date must equal health program end date!

To Correct –Verify entry and rekey date to Health Program End Date.

4020 – Open-ended elig required w/stop reason None!

To Correct –Correct date or add stop reason.

91001 – Invalid Date (MMDDCCYY)!

To Correct –Verify entry and rekey date in CCYY/MM/DD format.

91002 – Date must be numeric!

To Correct –Verify entry and rekey date in CCYY/MM/DD format.

91022 – Date cannot be greater than today's date!

To Correct –Verify entry and rekey date in CCYY/MM/DD format.

Field Name: *STOP REASON*

Description – Reason code for eligibility termination

Format – One character alphabetic. Valid values are the following:

G – Death

E – Regular

O – Open

Features – Pop-up window

Double-click to see pop-up window with valid stop reason codes

Select stop reason for pop-up window, if desired

Edits – 4135 – Invalid stop reason code; valid values are O, G, E

To Correct –Verify entry or select from pop-up window.

Other Messages

None

System Information

PBL – RECIP01.PBL

Window – W_RE_ELIG

W_ELIG_STOP_RSN

W_RE_HLTH_AID

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_ELIG

DW_ELIG_STOP_RSN

DW_RE_HLTH_AID

System Features

The Member Eligibility window contains a vertical scroll bar that allows the user to view the dates and stop reasons for health programs and aid categories of a chosen member. The **New Pgm** allows the user to add a new eligibility segment. The **New Aid** button allows the user to add a new aid category segment. The **Save** button allows the user to save the changes made to the eligibility window. The **Exit** button allows the user to exit the eligibility window and return to the previous window.

Section 5: Member Eligibility Replacement Window:

Introduction

The Member Eligibility Replacement window displays all instances of retroactively replaced eligibility. IFSSA and EDS use this window to monitor under which IHCP program a past claim has been paid. This window is accessed from the Member Search or Member Base window by clicking **ELIGIBILITY** under **OPTIONS** on the toolbar or by pressing **Alt+O**, **Alt+L**, and **Alt+R**. This window is for inquiry purposes only and is not updateable.

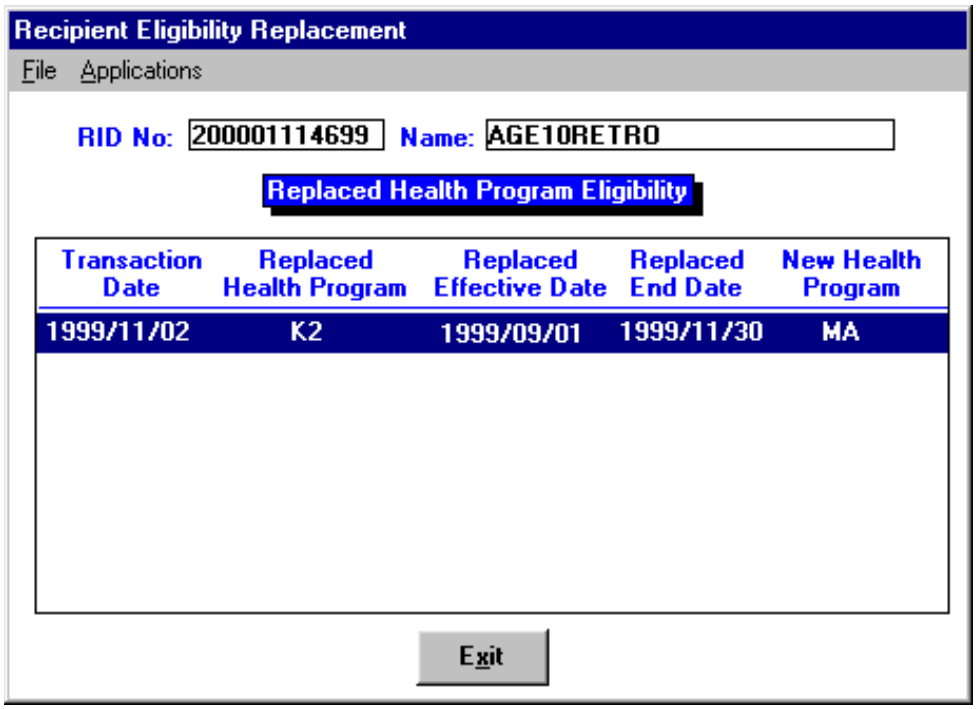

Figure 5.1 – Member Eligibility Replacement Window

File	Applications
Print	Adhoc Reporting
Exit	Claims
Exit IndianaAIM	Financial
	Managed Care
	MARS
	Prior Authorization
	Provider
	Member
	Reference
	Security
	SURS
	Third Party Liability

Figure 5.2 - Member Eligibility Replacement Menu Tree

Figure 5.2 is an illustration of a menu tree for the Member Eligibility Replacement Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options for the Member Eligibility Replacement Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print, exit the window, as well as exit Indiana*AIM*.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to the previous window

*Exit Indiana*AIM – Exits the user from Indiana*AIM*.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected - Display only

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member name

Format – Alphanumeric characters

Last Name, first name, and middle name

Features – Protected - Display only

Edits – None

To Correct – N/a

Field Name: *TRANSACTION DATE*

Description – Date that eligibility was replaced

Format – Date (YYYY/MM/DD)

Features – Protected - Display only

Edits – None

To Correct – N/a

Field Name: *REPLACED HEALTH PROGRAM*

Description – Health program coverage before the replacement took place

Format – Two alphanumeric characters. Valid values are displayed in Table 5.1.

Table 5.1 – Value Codes

Code	Program Name
59	590 Program
AR	ARCH
CS	Children with Special Health Care Services
K2	Package C
MA	Medicaid

Features – Protected - Display only

Edits – None

To Correct – N/a

Field Name: *REPLACED EFFECTIVE DATE*

Description – Effective date of replaced eligibility segment

Format –Date (YYYY/MM/DD)

Features – Protected - Display only

Edits –None

To Correct – N/a

Field Name: *REPLACED END DATE*

Description – End date of replaced eligibility segment

Format –Date (YYYY/MM/DD)

Features – Protected - Display only

Edits –None

To Correct – N/a

Field Name: *NEW HEALTH PROGRAM*

Description – Health program coverage after the replacement took place

Format – Two alphanumeric characters. Valid values are displayed in Table 5.2.

Table 5.2 – Value Codes

Code	Program Name
59	590 Program
AR	ARCH
CS	Children With Special Health Care Services
K2	Package C
MA	Medicaid

Features – Protected - Display only

Edits – None

To Correct – N/a

Other Messages

None

System Information

PBL – RECIP01.PBL

Window – W_RE_ELIG_REPL

Menu – M_RE_MAINTENANCE

Data Window – W_RE_NAME

DW_RE_ELIG_REPL

DWC_HLTH_PGM

System Features

Records are displayed in descending order based on the transaction date

Click **Exit** to close the window.

Section 6: Member Previous Names Window

Introduction

IFSSA and EDS use the Member Previous Names window to display previous names of a member. The Member Previous Names window is accessed through the Member Base window (or any other member window) by clicking **PREVIOUS** and **NAMES** under **OPTIONS** or by pressing **Alt+O**, **Shift+V**, and **Shift+N**. The member names are added or modified by authorized users via the Member Base window. The Member Names window is for display purposes only.

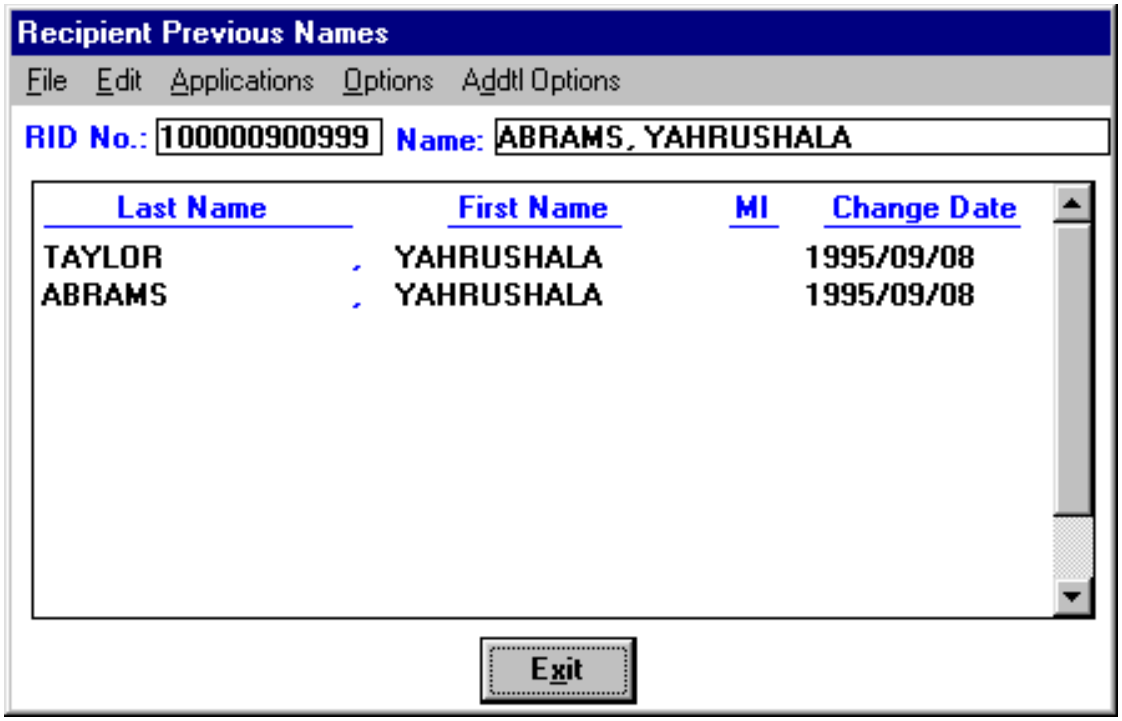

Figure 6.1 – Member Previous Names Window

File	Edit	Applications	Options		Addt'l Options
Delete	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Print	Paste	Claims	CSHCS		TPL Search/Resource
Exit	Cut	Financial	Eligibility-	Standard	
Audit		Managed Care		Replaced	
Exit Indiana*AIM*		MARS	EOMB Request		
		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 6.2 - Member Previous Names Window Menu Tree

Figure 6.2 is an illustration of a menu tree for the Member Previous Names Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Previous Names Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to deleted, print, exit the window, retrieve audit trail, as well as exit Indiana*AIM*.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the on-line audit trail windows.

Exit IndianaAIM – Exits the user out of Indiana*AIM*

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem

Base – Allows the user to access the Member Base Screen for the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access the standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers.
- Missed Appointment Codes.
- Periodicity Schedules.
- Member Abnormalities Member Notices.
- Member Screenings.

ID Cards – Allows the user to access the ID Card Window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization.

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage

- Dual Aid Eligibility
- Medicare Coverage
- Override, Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions.

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs or addresses.

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name*: RID NO.*

Description –Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name*: NAME*

Description – Current full name of the member

Format – 29 alphanumeric characters

Last name, first name, and middle initial

Features – Protected

Edits – None

To Correct – N/a

Field Name: *PREVIOUS LAST NAME*

Description – Previous last name of a member

Format – 15 alphabetic characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: ***PREVIOUS FIRST NAME***

Description – Previous first name of a member

Format – 13 alphabetic characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: ***PREVIOUS MI***

Description – Previous middle initial of the member

Format – One alphabetic character

Features – Protected

Edits – None

To Correct – N/a

Field Name: ***CHANGE DATE***

Description – Date that the member's name was changed

Format – Eight numeric characters (CCYY/MM/DD)

Features – None

Edits – None

To Correct – N/a

Other Messages

None

System Information

PBL – RECIP01.PBL

Window – W_RE_NAME_XREF

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_NAME_XREF

System Features

The Member Previous Names window contains a vertical scroll bar that allows the user to view the history of a member's previous names. **Exit** allows the user to exit the Member Previous Names window.

Section 7: Previous PCNs Window

Introduction

IFSSA and EDS use the Previous Pcns window to view previous PCNs known for a member. The Previous Pcns window can be accessed through the Member Base window (or any other member window) by clicking **PREVIOUS** and **PCN**, or by pressing **Alt+O**, **Shift+V**, and **Shift+P**.

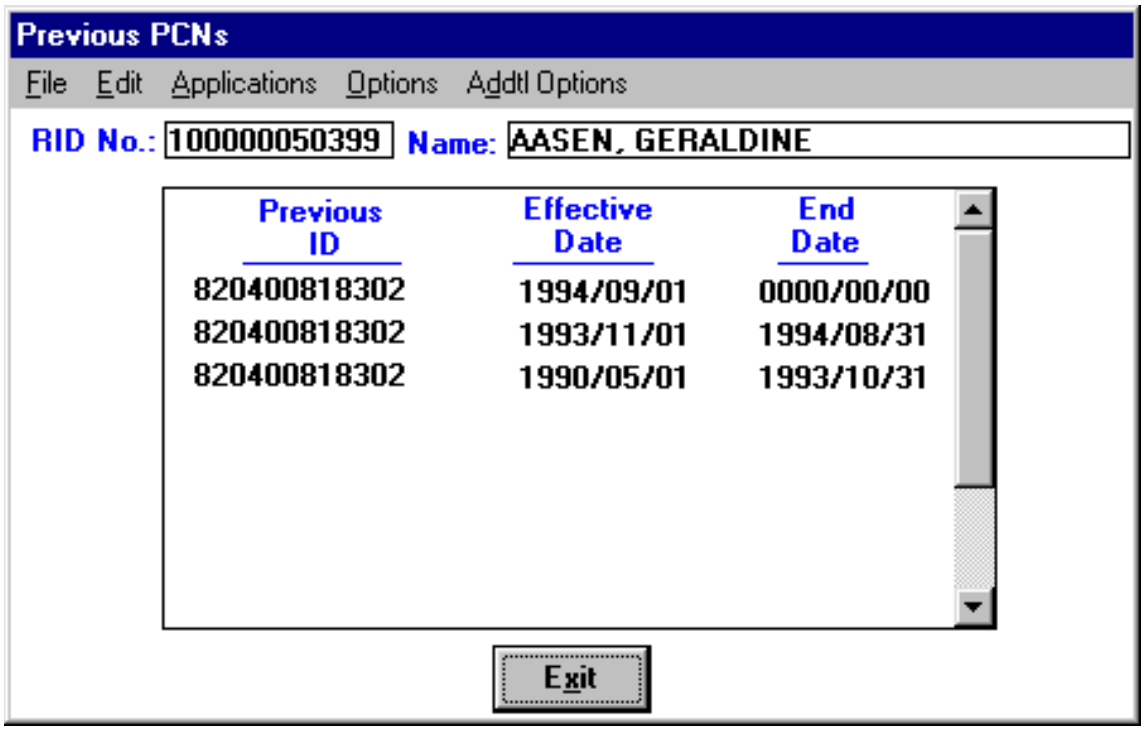

Figure 7.1 – Previous PCNs Window

File	Edit	Applications	Options		Addt'l Options
Delete	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Print	Paste	Claims	CSHCS		TPL Search/Resource
Exit	Cut	Financial	Eligibility	Standard	
Audit		Managed Care		Replaced	
Exit Indiana*AIM*		MARS	EOMB Request		
		Prior Authorization	EPSDT	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 7.2 - Previous PCNs Window Menu Tree

Figure 7.2 is an illustration of a menu tree for the Previous PCNs Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Previous PCNs Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Previous PCNs window and exit Indiana*AIM*.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

Exit IndianaAIM – Exits the user from Indiana*AIM*.

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to gain access to all the functional areas available in the Indiana*AIM* system.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request Window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices Member Screenings.

ID Cards – Allows the user to access the ID Card Window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to of select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization.

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility

- Medicare Coverage Override
- Part B Billing
- Part A Billing
- Premium 150 Premium
- S15 Premium
- 150 Exceptions Premium
- S15 Exceptions.

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options: Names Pcns Addresses.

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking on **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO*

Description –Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Full name of the member

Format – 29 alphanumeric characters

Last name, first name and middle initial

Features – Protected

Edits – None

To Correct – N/a

Field Name: *PREVIOUS ID*

Description – Member's previous identification number(s)

Format – 12 numeric characters

Features – None

Edits – None

To Correct – N/a

Field Name: *EFFECTIVE DATE*

Description –Beginning eligibility date of the corresponding previous ID

Format – Eight numeric characters (CCYY/MM/DD)

Features – None

Edits – None

To Correct – N/a

Field Name: *END DATE*

Description – The ending date of eligibility for the corresponding previous ID

Format – Eight numeric characters (CCYY/MM/DD)

Features – None

Edits – None

To Correct – N/a

Other Messages

None

System Information

PBL – RECIP01.PBL

Window – W_RE_OLDPCN

Menu – M_RE_MAINTENANCE

Date Windows – DW_RE_OLDPCN

System Features

The Previous PCNs window uses a vertical scroll bar that allows the user to view a member's previous IDs, the effective date, and the end date of those IDs. **Exit** allows the user to exit the Previous PCNs window.

Section 8: Member Previous Address Window

Introduction

IFSSA and EDS use the Member Previous Address window to view previous addresses known for a member. The Member Address window is accessed through the Member Base window (or any other window) by clicking on **PREVIOUS** and **ADDRESSES** or by pressing **Alt+O**, **Shift+V**, and **Shift+D**.

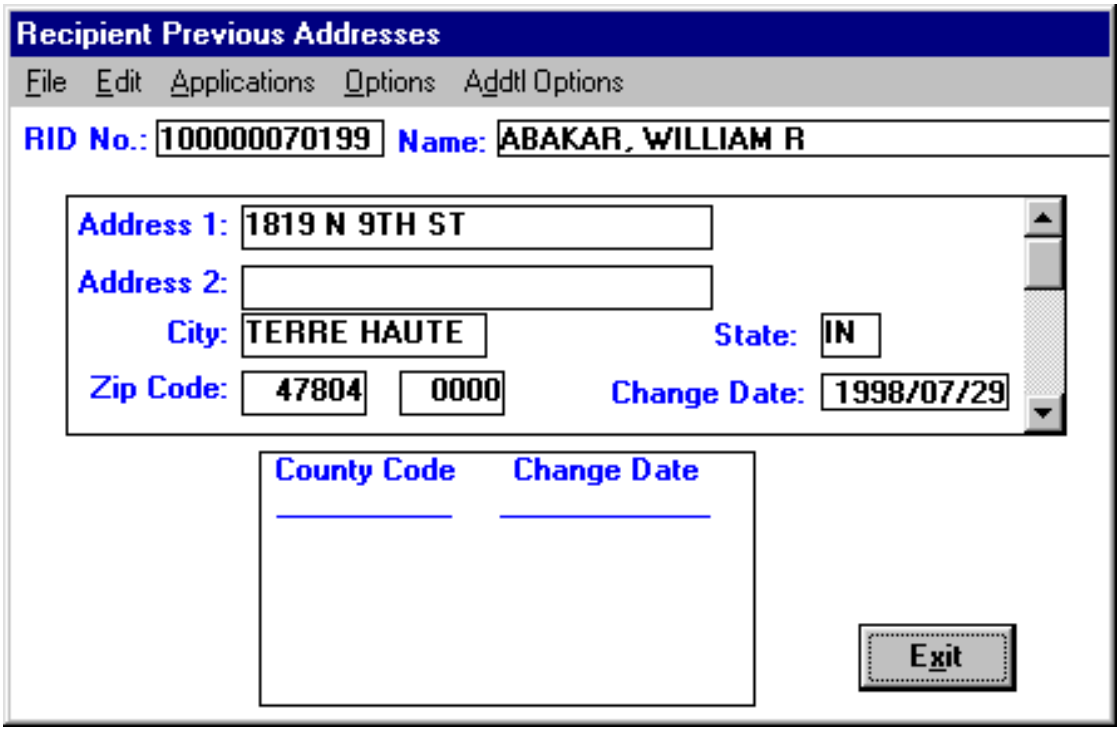

Figure 8.1 – Member Previous Address Window

File	Edit	Applications	Options		Addt'l Options
Delete	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Print	Paste	Claims	CSHCS		TPL Search/Resource
Exit	Cut	Financial	Eligibility-	Standard	
Audit		Managed Care		Replaced	
Exit Indiana*AIM*		MARS	EOMB Request		
		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		

(Continued)

File	Edit	Applications	Options		Addt'l Options
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 8.2 - Member Previous Address Window Menu Tree

Figure 8.2 is an illustration of a menu tree for the Member Previous Address Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Previous Address Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member Previous Address window, and exit Indiana*AIM*.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the on - line audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM* system.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop down - list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices

- Member Screenings.

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization.

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions.

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses.

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's first name, last name, and middle initial

Format – Last name - 15 alphanumeric characters

First name - 13 alphanumeric characters

Middle Initial - one alphanumeric character

Features – Protected

Edits – None

To Correct – N/a

Field Name: *ADDRESS 1*

Description – Address line 1 of the member's previous address

Format – 30 alphanumeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *ADDRESS 2*

Description – Address line 2 of the member's previous address

Format – 30 alphanumeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *CITY*

Description – The previous city of the member

Format – 15 alphanumeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *STATE*

Description – Previous state of the member

Format – Two alphabetic characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *ZIP CODE*

Description –Member's previous zip code

Format – Five numeric characters plus four numeric character

Features – Protected

Edits – None

To Correct – N/a

Field Name: *CHANGE DATE*

Description – Date of change of member's information

Format – Two numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *COUNTY CODE*

Description – Counties of prior residence

Format – Two numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *CHANGE DATE*

Description – Date the member's county code changed

Format – Two numeric characters

Features – None

Edits – None

To Correct – N/a

Other Messages

None

System Information

PBL – RECIP01.PBL

Window – W_RE_ADDRESS

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_ADDRESS

System Features

The Member Previous Address window contains two vertical scroll bars. The user can view the previous address information by scrolling up or down in the address window. The other scroll bar allows the user to view previous county codes and change dates.

Section 9: Member Level of Care Window

Introduction

The Member Level of Care window displays the level of care information for each member on the eligibility file. The Member Level of Care window is accessed through the Member Base window (or any other window) by clicking on **LEVEL OF CARE** or by pressing **Alt+O** and **Shift+C**.

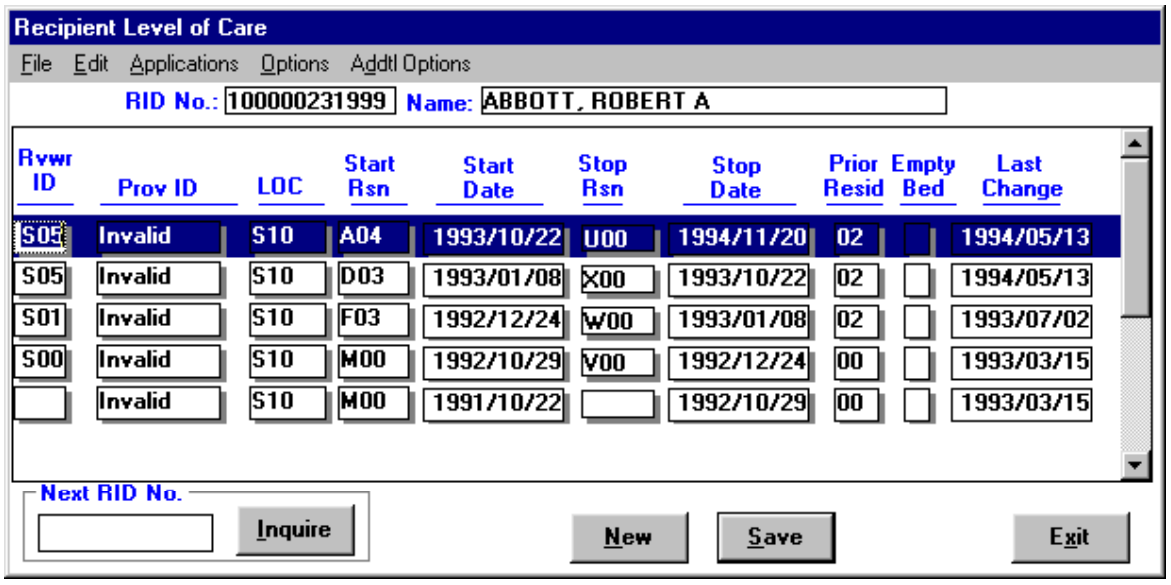

Figure 9.1 – Member Level of Care Window

File	Edit	Applications	Options		Addt'l Options
New	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Save	Paste	Claims	CSHCS		TPL Search/Resource
Print	Cut	Financial	Eligibility-	Standard	
Exit		Managed Care		Replaced	
Audit		MARS	EOMB Request		
Exit IndianaAIM		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 9.2 - Member Level of Care Window Menu Tree

Figure 9.2 is an illustration of a menu tree for the Member Level of Care Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Level of Care Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press ALT.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member Level of Care window, and exit Indiana*AIM*.

New – Allow user to add new information to the window.

Save – Saves entered information.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the on - line audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings.

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization.

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions.

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment –By clicking **Select** on the PMP Assignment window, to access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description –Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's last and first name

Format – 30 alphanumeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *REVIEWER ID*

Description – Reviewer identification. This identifies who made prior review determinations. Valid values are first character **E**, **S** or **W** and second and third character 00 through 99. This is a required field.

Format – Three alphanumeric characters

Features – None

Edits – 4016 - first position must be **E**, **W** or **S**

To Correct – Verify entry to ensure that the correct code has been used.

91006 - Reviewer ID Field is required

To Correct – Verify entry

91007 - second & third positions of data must be numeric!

To Correct – Verify entry.

Field Name: *PROVIDER ID*

Description – The provider number of the institution that is authorized to bill for long-term care rendered to the member. **PROVIDER ID** is a required field, however the message *"Warning 4027 (Provider is blank! Save anyway? Respond yes)"* will appear when no provider number is inserted. Respond **yes** to override this edit.

Format – Nine alphanumeric characters

Features – None

Edits – 91011 - Provider ID record not found. Please try again.

To Correct – Verify entry

Field Name: *LOC CODE*

Description – The level of care authorized for the member. Valid values are, A through N and P through Z.

Format – Three alphanumeric characters

Features – Double-click to a pop-up window with valid level of care codes. Select the desired level of care from the pop-up window illustrated in Table 9.1.

Table 9.1 – Level of Care Codes

Code	Description
51H	Hospice Program; Authorization for first 90 day period
52H	Hospice Program; Authorization for second 90 day period
53H	Hospice Program; Authorization for third period; unlimited 60 day segments
A	Intermediate Care Level; diverted, Disabled (Under Age 65) - HCBS Waiver Effective 7-1-90
B	Intermediate Care Level; Deinstitutionalized, Disabled (Under Age 65) - HCBS Waiver Effective 7-1-90
C	Skilled Care Level; Diverted, Disabled (Under Age 65) - HCBS Waiver Effective 7-1-90
D	Skilled Care Level; Deinstitutionalized, Disabled (Under Age 65) - HCBS Waiver Effective 7-1-90
E	Intermediate Care Level; Diverted, Aged (65 and Over) - HCBS Waiver Effective 7-1-90
F	Intermediate Care Level; Deinstitutionalized, Aged (65 and Over) - HCBS Waiver Effective 7-1-90
G	Skilled Care Level; Diverted, Aged (65 and Over) - HCBS Waiver Effective 7-1-90
H	Skilled Care Level;Deinstitutionalized, Aged (65 and Over) - HCBS Waiver Effective 7-1-90
I10	General Intermediate Care in AIDS NF; Effective 10-1-98
I11	MR/DD specialized intermediate care in NF
I13	AIDS Intermediate Care in NF; Effective 10-1-98
I20	ICF/MR
J	Medically Fragile Children; Diverted - Hospital; Effective 7-1-92
K10	TBI Waiver: Diverted-NF LOC (from In-state placement); Effective 1-1-00
K11	TBI Waiver: Diverted-ICF/MR LOC (from In-state placement); Eff 1-1-00
K12	TBI Waiver: Diverted-Hospital LOC (from In-state placement); Eff 1-1-00
L10	TBI Waiver: Deinst-NF LOC (from In-state placement); Eff 1-1-00
L11	TBI Waiver: Deinst-ICF/MR LOC (from In-state placement); Eff 1-1-00
L12	TBI Waiver: Deinst-Hospital LOC (from In-state placement); Eff 1-1-00
L20	TBI Waiver: Deinst-NF LOC (from Out-of-state placement); Eff 1-1-00
L21	TBI Waiver: Deinst-ICF/MR LOC (from Out-of-state placement); Eff 1-1-00
L22	TBI Waiver: Deinst-Hospital LOC (from Out-of-state placement); Eff 1-1-00
N	Nursing Facility Level of Care
P	Autistic Waiver, Diverted, Effective 7-1-90
Q	Autistic Waiver, Deinsitutionalized, Effective 7-1-90
R	Rehabilitation Care; Terminated 10-1-98
S10	General Skilled Care in AIDS NF, Effective 10-1-98

(Continued)

Table 9.1 – Level of Care Codes

Code	Description
S11	MR/DD specialized skilled care in NF
S12	Vent Skilled Care Unit in NF; Terminated 10-1-98
S13	AIDs skilled care unit in NF
S14	TBI Skilled Care Unit in NF; Terminated 10-1-98
S15	Extensive Skilled Care Unit in NF; Terminated 10-1-98
T	DD HCBS Waiver: Diverted; Effective 5-1-92
T01	DD HCBS Waiver: Diverted-317 Funding Priority Waiver slot; Eff 7-1-99
T02	DD HCBS Waiver: Diverted-317 General Funding (Non-priority slot); Eff 7-1-99
U00	DD HCBS Waiver: Deinst From Non-state Facility; Eff 5-1-92
U01	DD HCBS Waiver: Deinst From Non-state Facility-317 Funding Priority Waiver slot; Eff 7-1-99
U02	DD HCBS Waiver: Deinst From Non-state Facility-317 General Funding (Non-priority slot); Eff 7-1-99
U10	DD HCBS Waiver: Conversion Group Home (Small Private)
U20	DD HCBS Waiver: Conversion Res-Care (Large Private)
U21	DD HCBS Waiver: Conversion SVNH (Large Private)
U22	DD HCBS Waiver: Conversion Arcadia (Large Private)
U23	DD HCBS Waiver: Conversion Holy Cross Living Center (Large Private)
U24	DD HCBS Waiver: Conversion Knox Co. ARC (Large Private)
U25	DD HCBS Waiver: Conversion Millers Merry Manor (Large Private)
U26	DD HCBS Waiver: Conversion New Horizon Dev Cntr (Large Private)
U27	DD HCBS Waiver: Conversion Normal Life of Indiana (Large Private)
U28	DD HCBS Waiver: Conversion North Willow Center (Large Private)
U29	DD HCBS Waiver: Cascade due to Non-State Facility Conversion
U30	DD HCBS Waiver: Conversion Oak Meadows Learning Cntr (Large Private)
U31	DD HCBS Waiver: Conversion Procare Developmental Cntr (Large Private)
U32	DD HCBS Waiver: Conversion Riverbend Learning Cntr (Large Private)
V00	DD HCBS Waiver: Deinst From State Facility; Eff 5-1-92
V01	DD HCBS Waiver: Deinst From State Facility-317 Funding Priority Waiver slot; Eff 7-1-99
V20	DD HCBS Waiver: Conversion Central State Hospital
V21	DD HCBS Waiver: Conversion NCSDC; Effective 7-1-96
V22	DD HCBS Waiver: Conversion NISDC; Effective 7-1-96
V23	DD HCBS Waiver: Conversion FWSDC; Effective 7-1-96
V24	DD HCBS Waiver: Conversion MSDC; Effective 7-1-96
V25	DD HCBS Waiver: Conversion Evansville SH/DTU; Eff 7-1-96

(Continued)

Table 9.1 – Level of Care Codes

Code	Description
V26	DD HCBS Waiver: Conversion Madison/Gold; Eff 7-1-96
V27	DD HCBS Waiver: Conversion Logansport JEU; Eff 7-1-96
V29	DD HCBS Waiver: Cascade due to State Facility Conversion
W	DD HCBS Waiver: Deinst From Nursing Facility; Eff 5-1-92
W01	DD HCBS Waiver: Deinst From Nursing Facility-317 Funding Priority Waiver slot; Eff 7-1-99
X	Medically Fragile Children; Deinstitutionalized - Hospital; Effective 7-1-92
Y	Medically Fragile Children; Diverted - Nursing Facility Skilled Care; Effective 7-1-92
Z	Medically Fragile Children; Deinstitutionalized - Nursing Facility Skilled Care; Effective 7-1-92

Edits – 91006 - Level of care field is required.

To Correct – Verify entry.

91011 - LOC record not found - please try again!

To Correct – Verify entry.

Field Name: *START REASON CODE*

Description – The reason the member is authorized to receive this service. Valid values for the first character is A through N, P through V and the second and third character is a 00 through 12, 20 through 28, 30 through 39, 41 through 48.

Format – Three alphanumeric characters

Features – Double-click to see a pop-up window with valid start reason codes. Select start reason from pop-up window if desired. The start reason code valid values are shown in Table 9.2:

Table 9.2 – Start Reason Codes

Code	Description
A	PAS case (PAS completed - new admission)
B	LOC Change request from facility
C	LOC review team transfer
D	Facility requests continued LOC
E	Change of facility (same LOC)
F	Re-admission (same LOC)
G	Change to intermediate LOC following temporary approved skilled LOC
H	LOC review at time of Medicaid eligibility
I	ICF/MR admission
J	HCBS waiver admission/continued care
K	Continued under appeal process/appeal decision
L	Reconsideration from additional information
M	Conversion default
N	PAS (1 year penalty or late PAS penalty)
P	"PASARR" nursing facility admission request
Q	Incomplete PAS case (discharge from facility prior to completion of PAS)
R	Rehab admission to facility
S	Change of facility
T	Re-admission (LOC change)
U	Admission to facility from HCBS waiver
V	Medicaid coverage following Medicare services
X	Medicaid coverage following VA or other coverage

Entry for the second and third characters must be as shown in Table 9.3:

Table 9.3 – Start Reason Code second and third characters

Code	Description
00	Empty code (also for HCBS waiver)
01	Approved-intermediate
02	Approved-total body care
03	Approved-skilled procedure
04	Approved-instability/skilled observation
05	Approved-rehabilitation (skilled)
06	Denied intermediate request - no LOC
07	Denied intermediate request-approve/continue skilled
08	Denied request - no LOC
09	Denied skilled request -approve/ continue intermediate
10	Denied - Does not meet ICF/MR level of care criteria
11	Member upheld in appeal decision
12	Denied skilled request - approved intermediate total body care
13	Denied - Nursing Facility failure to obtain PAS
14	Approved - Medicare skilled covered days
15	Approved skilled - date later than requested
20	Approved - ICF/MR (Default)
21	Approved - State operated facility (ICF/MR)
22	Approved - Large private ICF/MR
23	Approved - Basic developmental ICF/MR
24	Approved - Child rearing with behavioral management ICF/MR
25	Approved - Child Rearing ICF/MR
26	Approved intensive training ICF/MR
27	Approved - Sheltered ICF/MR
28	Approved - Intensive training with behavior management ICF/MR
30	Approved - PASARR exempted hospital discharge to NF (Intermediate)
31	Approved - PASARR exempted hospital discharge to NF (Skilled)
32	Approved - PASARR respite short-term (intermediate)
33	Approved - PASARR respite short-term (Skilled)
34	Approved - PASARR adult protective services 7-day (Intermediate)

(Continued)

Table 9.3 – Start Reason Code second and third characters

Code	Description
35	Approved - PASARR adult protective services 7-day (Skilled)
36	Denied - PASARR exempted hospital discharge to NF
37	Denied - PASARR respite short-term
38	Denied - PASARR adult protective services
39	Denied - General PASARR admission request
41	Denied skilled request - Approve PASARR exempted hospital disc
42	Deny skilled - Approve intermediate-PASARR respite
43	Deny Skilled - Approve intermed - PASARR APS (7 day)
44	Deny skilled - Approve intermed - PASARR short-term
45	Approve - Intermed PASARR - gen'l short-term adm
46	Approve - PASARR gen'l short-term skilled procedure
47	Approve - PASARR gen'l short-term Sk-instability/obs
48	Approve - PASARR gen'l short-term skilled - rehab
60	Approved - Extensive care - rehabilitation
61	Approved - Extensive care - trach care
62	Approved - Extensive care - respiratory care
63	Approved - Extensive care/vent care
64	Approved - Vent care rate
65	Denied extensive care/vent requested - approved/cont intermed
66	Denied extensive care/vent request - approved/continue skilled proce
67	Denied extensive care/vent instability/skilled observation
68	Denied extensive care/vent request - approved rehab (skilled)
80	Transfer of property penalty ended
81	Transfer of property penalty appealed

Edits – 91006 - Start Reason Code field is required

To Correct – Verify entry.

91011 - Start Reason Code record not found - please try again!

To Correct – Verify entry.

Field Name: *START DATE*

Description – The date that the corresponding provider is authorized to bill for the corresponding level of care. *"Error 4026 (Eff Dt not = to*

end date of prev segment! Save anyway? Respond yes)" will appear when start date is not equal to previous end date. Respond **yes** to override this edit.

Format – Eight numeric characters (CCYY/MM/DD)

Features – None

Edits – 4011 - Effective date must be less than or equal to the end date!

To Correct – Verify entry and eligibility.

4024 - Effective Date must be during eligibility!

To Correct – Verify entry and eligibility.

91001 - Invalid Date (CCYY/MM/DD)!

To Correct – Verify entry.

91002 - Date must be numeric!

To Correct – Verify entry.

91003 - Date is required!

To Correct – Verify entry.

91030 - Level of Care date segments may not overlap!

To Correct – Verify entry.

Field Name: *STOP REASON CODE*

Description – The reason that a person is no longer authorized to receive the corresponding level of care. Valid values are F through Z.

Format – Three alphanumeric characters

Features – Double-click to see a pop-up window with valid stop reason codes. Select stop reason from pop-up window if desired. The stop reason code valid values are as shown in Table 9.4:

Table 9.4 – Stop Reason Codes

Code	Description
F	Reconsideration/appeal-State decision upheld
G	Reconsideration/appeal requested
H	Denied-No LOC
I	End of Current Denial/Appeal Period of Ineligibility
J	Replacement facility (ICF/MR provider moved to new home)
K	Medicare coverage begins
L	Transfer from facility to facility (no break in service)
M	Automatic stop - UB 92 claim discharge
N	Automatic Stop - No claim activity
O	LOC review team recommended transfer (for I to S or S to I transfers)
P	LOC review team recommended discharge (No LOC)
Q	Transfer from facility to waiver case
R	Waiver case - no longer eligible
S	No longer meets LOC criteria
T	PASARR - other (active treatment needs exceed nursing facility needs)
U	PASARR - short-term stay (respite, APS, exempt hospital, other short term)
V	LOC change request from facility
W	End of temporary upgrade of LOC
X	Discharge from facility (break in service)
Y	Death
Z	Termination of Medicaid elig/or restriction

Entry for the second and third characters must be as shown in Figure 9.5.

Table 9.5 – Stop Reason Code second and third characters

Code	Description
00	Level of Care Code (Default)
01	1704 temporary upgrade - LOC
02	RN requires updated information (nursing facility)
03	QMRP requires updated information (ICF/MR)
04	End of waiver short-term LOC
05	No 450B from NF to start LOC
06	End of Medicare bed-hold
07	Onset of managed care coverage
10	Readmission from hospital/bed-hold expired
11	Discharge to community
20	State decision upheld
21	State rescinded on reconsideration
22	Appellant upheld
23	Appellant withdrew appeal
30	Transfer of property penalty
99	AIM Stop 2 Conversion Code

Edits – 4023 - End date requires stop reason.

To Correct – Verify entry.

4031 - Open end date requires blank stop reason

To Correct – Verify entry.

91011 - Stop Reason record not found - Please try again!

To Correct – Verify entry.

4032 - End Date must be during eligibility.

To Correct – Verify entry and eligibility.

Field Name: *END DATE*

Description – The end date is the date following the last date that the provider is authorized to bill for the corresponding level of care. End

date must be on or after the start date for same segment **and** must be on or before the start date of next segment. *(Note: The stop date is not an approved date for that level of care).*

Format – Eight numeric characters (CCYY/MM/DD)

Features – None.

Edits – 91001 - Invalid date (CCYY/MM/DD).

To Correct – Verify entry.

91002 - Date must be numeric.

To Correct – Verify entry.

Field Name: *PRIOR RESIDENCE CODE*

Description – Where the member resided prior to admission to this facility. For in-state residents, valid values are 00 through 12. Otherwise, valid values for out of state residence may be a two-character state abbreviation.

Format – Two character alphabetic or numeric

Features – Double-click to see a pop-up window with valid prior residence codes. Select prior residence from pop-up window if desired. Prior residence code valid values are as shown in Table 9.6:

Table 9.6 – Prior Residence Codes

Code	Description
00	Indiana Only-Undefined
01	Indiana Only-Home
02	Indiana Only-Hospital-Acute Care
03	Indiana Only-Hospital-Rehab
04	Indiana Only-State Hospital
05	Indiana Only-State Hospital - Psychiatric
06	Indiana Only-ICF/MR (Undifferentiated)
07	Indiana Only-ICF/MR (Large Private)
08	Indiana Only-ICF/MR (Small Private)
09	Indiana Only-Psychiatric Hospital/Unit
10	Indiana Only-Nursing Facility
11	Indiana Only-Residential Facility (ARCH/RBA)
12	Incarcerated

Otherwise, valid entry codes for out-of-state residence may be first and second character state abbreviation.

Table 9.7 –State Abbreviation

Code	State Name	Code	State Name
AK	Alaska	NV	Nevada
AL	Alabama	NY	New York
AR	Arkansas	OH	Ohio
AZ	Arizona	OK	Oklahoma
CA	California	MN	Minnesota
CN	Connecticut	MO	Missouri
CO	Colorado	MS	Mississippi
DE	Delaware	MT	Montana
FL	Florida	NC	North Carolina
GA	Georgia	ND	North Dakota
HI	Hawaii	NE	Nebraska
IA	Iowa	OR	Oregon
ID	Idaho	PA	Pennsylvania
IL	Illinois	RI	Rhode Island
IN	Indiana	SC	South Carolina

(Continued)

Table 9.7 –State Abbreviation

Code	State Name	Code	State Name
KS	Kansas	SD	South Dakota
KY	Kentucky	TN	Tennessee
LA	Louisiana	TX	Texas
MA	Massachusetts	UT	Utah
MD	Maryland	VA	Virginia
ME	Maine	WA	Washington
NH	New Hampshire	WI	Wisconsin
NJ	New Jersey	WV	West Virginia
MN	New Mexico	WY	Wyoming

Edits – 91006 - Prior Residence field is required.

To Correct – Verify entry.

91011 - Prior Residence record not found - Please try again.

To Correct – Verify entry.

Field Name: *EMPTY BED INDICATOR*

Description – Indicates empty bed request. Valid values are **A**, **B**, or **C** with a state abbreviation prior residence code applies.

Format – One alphabetic character

Features – Double-click to see a pop-up window with valid empty bed indicator codes. Select empty bed indicator from a pop-up window, if desired. Empty Bed Indicator valid values are the following:

- *A* - Resident Solely Requires Empty Bed
- *B* - Resident Desires to Become Indiana Resident
- *C* - Uncertain

Edits – 91011 - Empty Bed Record not found - please try again!

To Correct – Verify entry. Valid values are **A**, **B**, and **C**.

4029 - Empty Bed required for out state members.

To Correct – Verify entry.

4030 - Empty Bed must be blank for in state members.

To Correct – Verify entry.

Field Name: *LAST CHANGE DATE*

Description – The last change date indicates last date of a successful change or adds of level of care segment. This field is automatically populated with the current date.

Format – Eight numeric characters (CCYY/MM/DD)

Features – Protected.

Edits – None

To Correct –N/a

Field Name: *NEXT RID NO*

Description – Allows user to search for another member

Format – 12 numeric characters

Features – None

Edits – 4003-Next RID Number must be 12 characters!

To Correct –Verify entry. The RID No. must be 12 characters.

91046-New Key is required!

To Correct –An entry is required in order to search for a member. Key in the ID or choose an alternative search option.

4003-Next RID No. must be 12 numeric!

To Correct –Enter a 12 character numeric value.

4100-No match found for RID No.!

To Correct –Enter a valid RID No. There was not a match on the member file for the ID typed.

Other Messages: Edits

None

System Information

PBL – RECIP03.PBL

Window – W_RE_LOC

W_RE_LOC_CODE

W_RE_LOC_STOP

W_RE_LOC_STRT

W_RE_PRIOR_RES

W_RE_EMPTY_BED

Data Windows – DW_RE_LOC

DW_RE_LOC_CODE

DW_RE_LOC_STOP

DW_RE_LOC_STRT1

DW_RE_LOC_STRT2

DW_RE_PRIOR_RES

DW_RE_EMPTY_BED

Menu – M_RE_MAINTENANCE

Section 10: Member Patient Liability Window

Introduction

IFSSA and EDS use the Member Patient Liability window to view patient liability information about long-term care members. The patient liability information is accessed during claims processing to determine the correct monthly patient liability amount to be used on the claim. The Patient Liability window is accessed through the Member Base window (after search criteria has been entered) by clicking on the **PATIENT LIABILITY**, or by pressing **Alt+O** and **Shift+T**.

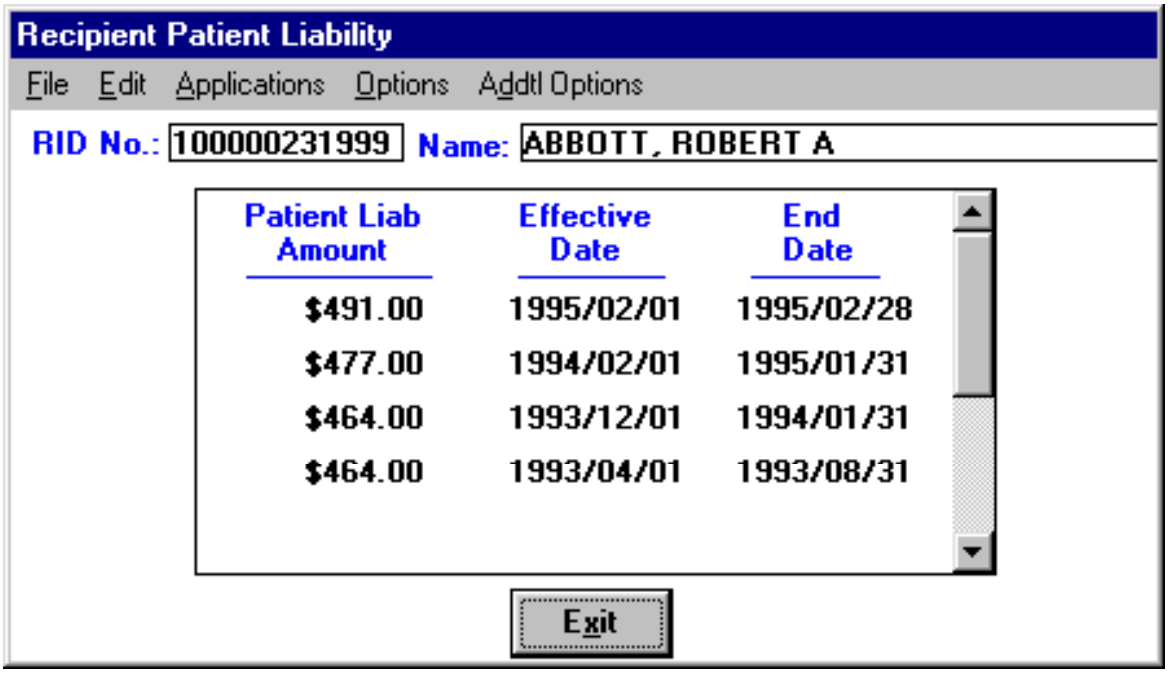

Figure 10.1 – Member Patient Liability Window

File	Edit	Applications	Options		Addt'l Options
Delete	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Print	Paste	Claims	CSHCS		TPL Search/Resource
Exit	Cut	Financial	Eligibility-	Standard	
Audit		Managed Care		Replaced	
Exit Indiana*AIM*		MARS	EOMB Request		
		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 10.2 - Member Patient Liability Window Menu Tree

Figure 10.2 is an illustration of a menu tree for the Member Patient Liability Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Patient Liability Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member Patient Liability window and exit Indiana*AIM*.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*.

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in the Indiana*AIM* system.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings.

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Locki. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches

- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO*

Description – The member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Full name of the member

Format – 29 alphabetic characters last name, first name and middle initial.

Features – Protected

Edits – None

To Correct – N/a

Field Name: *PATIENT LIABILITY AMOUNT*

Description – Patient's financial liability amount that must be paid by the member before IHCP will make payment on the claim

Format – Six numeric characters

Features – Protected

Edits – None

To Correct – N/a

Field Name: *EFFECT DTE*

Description – Date that the patient's financial liability amount becomes effective

Format – Eight numeric characters (CCYY/MM/DD)

Features – Protected

Edits – None

To Correct – N/a

Field Name: *END DATE*

Description –Date that the patient financial liability amount is no longer effective for a member in a long-term facility.

Format – Eight numeric characters (CCYY/MM/DD)

Features – Protected

Edits – None

To Correct – N/a

Other Messages

None

System Information

PBL – RECIP01.PBL

Window – W_RE_PAT_LIAB

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_PAT_LIAB

System Features

Scroll bars are displayed at the right edges of the window. The scroll boxes inside the scroll bars indicate the vertical location in the document. Use the mouse to scroll to other parts of the document.

Click on the up arrow to scroll up one line.

Click on and drag the box in the scroll bar, to move to an approximate location in the document.

Click the down arrow to scroll down one line.

Click **Exit** to exit the Member Patient Liability window.

Section 11: Spenddown Liability Window

Introduction

IFSSA and EDS use the Spenddown Liability window to view a member's spenddown effective dates. This window displays the periods of spenddown eligibility and the date satisfied that ICES sends to Indiana*AIM* for that member. The Spenddown Liability window is accessed through the **SPENDDOWN** option button, or by pressing **Alt+O** and **Alt+S**.

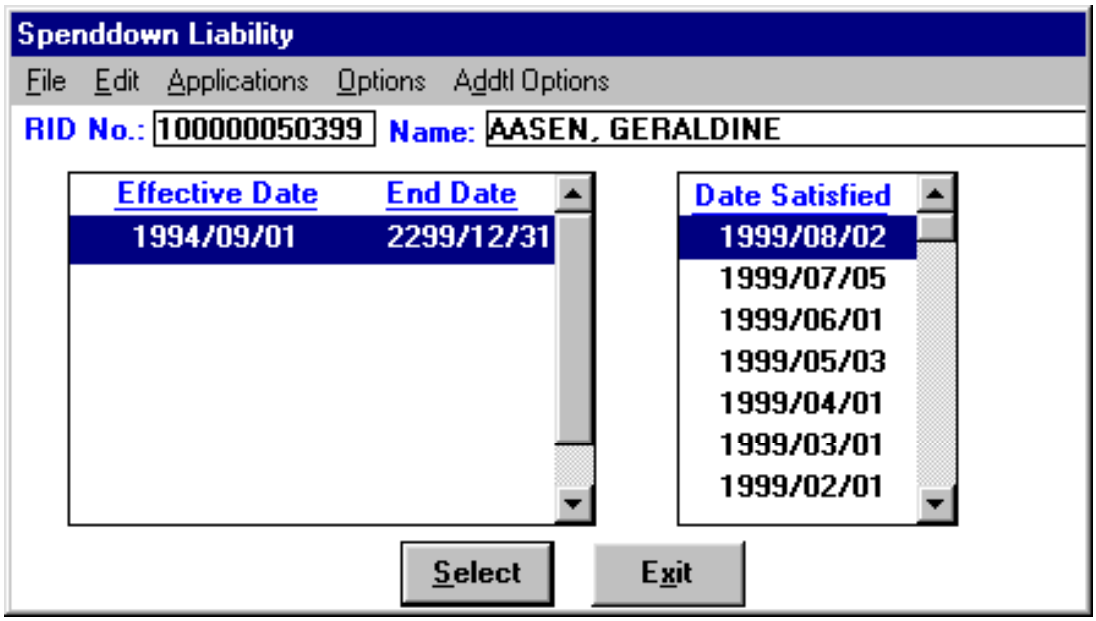

Figure 11.1 – Spenddown Liability Window

File	Edit	Applications	Options		Addt'l Options
Delete	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Print	Paste	Claims	CSHCS		TPL Search/Resource
Exit	Cut	Financial	Eligibility	Standard	
Audit		Managed Care		Replaced	
Exit Indiana*AIM*		MARS	EOMB Request		
		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 11.2 - Spenddown Liability Window Menu Tree

Figure 11.2 is an illustration of a menu tree for the Spenddown Liability Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Spenddown Liability window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1 Click on the command or window option title.

2 Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member Spenddown Liability window and exit Indiana*AIM*.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

Exit IndianaAIM – Exits the user from Indiana*AIM*

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in the Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings.

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End
- Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches

- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected-display only

Edits – None

To Correct – N/a

Field Name: *MEMBER NAME*

Description – Member's name

Format – 29 alphanumeric characters with special character options (space, hyphen, and apostrophe)

Features – Protected-display only

Edits – None

To Correct – N/a

Field Name: *EFFECTIVE DATE*

Description – Begin date for spenddown

Format – Eight numeric characters (CCYY/MM/DD)

Features – Protected-display only

Edits – None

To Correct – N/a

Field Name: *END DATE*

Description – End date for spenddown

Format – Eight numeric characters (CCYY/MM/DD)

Features – Protected-display only

Edits – None

To Correct – N/a

Field Name: *DATE SATISFIED*

Description –Date spenddown was met

Format – Eight numeric characters (CCYY/MM/DD)

Features – Protected-display only

Edits – None

To Correct – N/a

Other Messages

None

System Information

PBL – RECIP03.PBL

Window – W_RE_SPEND_LIAB

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_SPEND_LIAB

System Features

By clicking **Select** the user can view all Dates Satisfied for the highlighted segment. Also, the user can click twice on the highlighted segment to view all Dates Satisfied for the highlighted segment. The **Exit** button at the bottom of the page allows the user to exit the window.

Section 12: Member Restriction Periods Window

Introduction

The Member Restrictions Periods window is the point of initial entry to lock a member in or out, or to inquire about a member's specific lockin (restriction) segment. This window is used to access to the following functions:

- Update a member's restriction period
- Access the Member Providers per Restriction Period window.

The Member Restriction Periods window is accessed through the Member Base window by clicking **LOCKIN** and clicking **LOCKIN BASE** or by pressing **Alt+O**, **Shift+K**, **Shift+K**. The **New Period** button on the Member Restriction Periods window will allow the creation of new restriction segments by pressing **Alt+N**. All previous segments shift down to display the new segment in the first segment position.

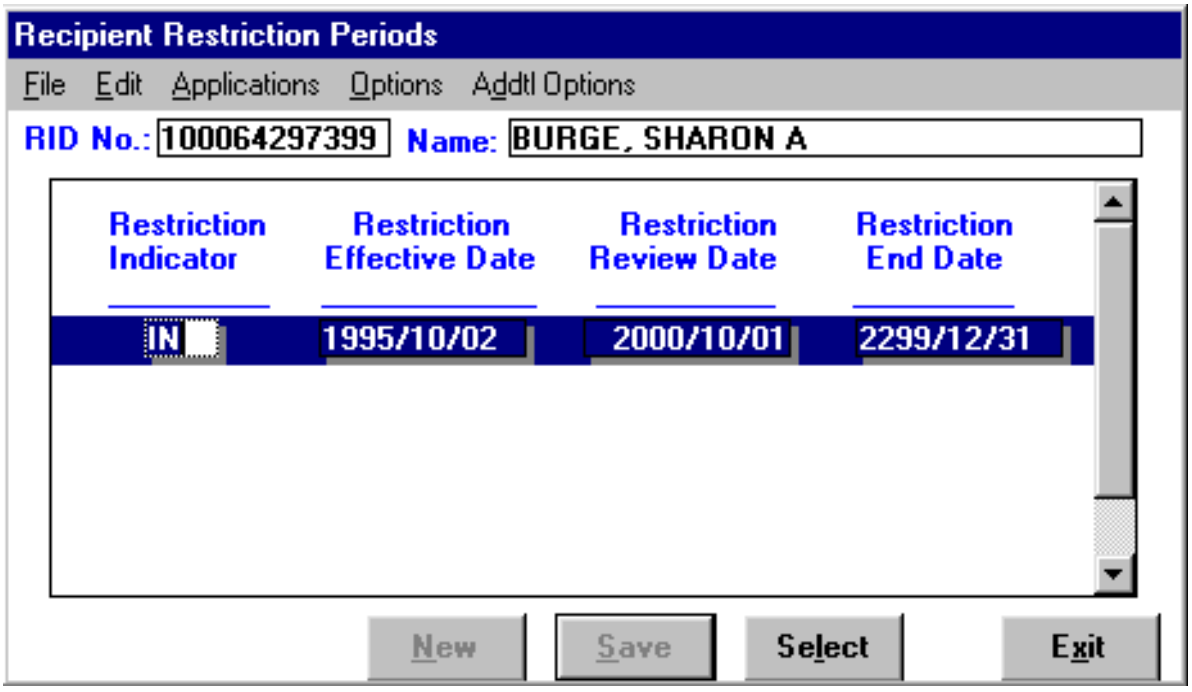

Figure 12.1 – Member Restriction Periods Window

File	Edit	Applications	Options		Addt'l Options
New	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Save	Paste	Claims	CSHCS		TPL Search/Resource
Delete	Cut	Financial	Eligibility-	Standard	
Print		Managed Care		Replaced	
Exit		MARS	EOMB Request		
Audit		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
Exit Indiana*AIM*		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 12.2 - Member Restriction Periods Window Menu Tree

Figure 12.2 is an illustration of a menu tree for the Member Restriction Periods Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Restriction Periods Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1 Click on the command or window option title.

2 Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member Restriction Periods window and exit Indiana*AIM*.

New – Allows user to add new information to the window.

Save – Saves entered information.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*.

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM* system.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user Care to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop down - list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description –Member identification number assigned by ICES

Format – 12 numeric characters

Features – System generated

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's name in last, first format

Format – Alpha numeric

Features – System generated

Edits – None

To Correct – N/a

Field Name: *RESTRICTION INDICATOR*

Description – Type of Restriction.

Valid values are the following:

- *IN* – Locked in
- *OUT* – Locked out

Format – Three alphabetic characters

Features – None

Edits – 91006-Restriction Indicator Field is required!

To Correct – Key **I** or **O** in Restriction Indicator field, Restriction Indicator must be **I** or **O.**

To Correct – Verify Entry. Enter *O* or *I*.

Field Name: *RESTRICTION EFFECTIVE DATE*

Description – First date of service for which the member's claims will be subject to restriction

Format – CCYY/MM/DD or YY/MM/DD

Features – Queue system generated Restriction Member Notification Letter at save.

Edits – 91002-Date must be numeric!

To Correct – Verify entry. The date must be numeric.

8017 – Effective date must be >=1976/01/01

To Correct – Verify entry. The date must be greater than or equal to 01/01/1976.

91033 – Date must be less than 12-31-2299

To Correct – Verify entry. The date must be less than 12/31/2299.

5025 – Date must be CCYYMMDD or YYMMDD format.

To Correct – Verify entry. The date must be in the correct form.

8034 – Date range overlaps existing segment

To Correct – Verify entry. Previous segment end date must be less than subsequent effective date.

5028 – End date is required.

To Correct – Verify entry. Previous segment end date must be present.

4011 – Effective Date must be <=End Date!

To Correct – Verify entry. Effective date must be less or equal to the end date.

4108 – Please add provider information!

To Correct – Add corresponding provider information.

4118 – A Provider's range is outside the period range!

To Correct – Add corresponding provider information.

Field Name: *RESTRICTION REVIEW DATE*

Description –Date that the member is scheduled for a 2/5 year restricted member review

Format – CCYY/MM/DD

Features – None

Edits – 91002-Date must be numeric!

To Correct – Verify entry. The date must be numeric.

8017 – Effective date must be >=1976/01/01

To Correct – Verify entry. The date must be greater than or equal to 01/01/1976.

91033 – Date must be less than 12/31/2299.

To Correct – Verify Entry. The date must be less than 12/31/2299.

5025 – Date must be in CCYYMMDD or YYMMDD format.

To Correct – Verify Entry. The date must be in correct format.

4110 – Review date must be >=effective date.

To Correct – Verify entry. Review date must be greater than the effective date.

8033 – Effective date is required.

To Correct – Enter effective date.

91030 – Lockin Period Date Segments may not overlap!

To Correct – Verify entry. Rekey Lockin Period date.

91001 – Invalid Date (CCYYMMDD)!

To Correct – Verify entry. Rekey date in CCYYMMDD format.

Field Name: *RESTRICTION END DATE*

Description – Last date of service for which the member's claims will be subject to restriction

Format – CCYY/MM/DD

Features – None

Edits – 91002-Date must be numeric!

To Correct – Verify entry. The date must be numeric.

91001 – Invalid Date (CCYYMMDD)!

To Correct – Verify Entry. Rekey date in CCYYMMDD format.

4011 – Effective Date must be <=End Date!

To Correct – Verify entry. Effective date must be less or equal to the end date.

91033 – Date must be less than 12-31-2299.

To Correct – Verify entry. The date must be less then 12/31/2299.

91003 – Date is required!

To Correct – Enter a valid date.

4118 – A provider's range is outside the period range!

To Correct – Add corresponding provider information.

Other Messages: Edits:

4108 – Please add Provider information.

System Information

PBL – RECIP02.PBL

Window – W_RE_LOCKIN_PERIOD

Menu – M_RE_MAINTENACE

Data Window – DW_RE_LOCK_PERIOD

Section 13: Member Providers Per Restriction Periods Window

Introduction

The Member Providers Per Restriction Period window will be the entry point for, inquiry about providers to which a member is locked in or out. This window is used to access the following functions:

- Update a member's providers.
- Access the Member Restrictions Detail Window.

The Members Providers Per Restriction Period window will be accessed through the Member Restriction Period window by highlighting a segment and clicking **SELECT**, or by pressing **Alt+L**. The **New** button on the Member Providers Per Restriction Period window will allow the creation of new provider segments by clicking the button, or pressing **Alt+N**. All previous segments shift down to display the new segment in the first segment position.

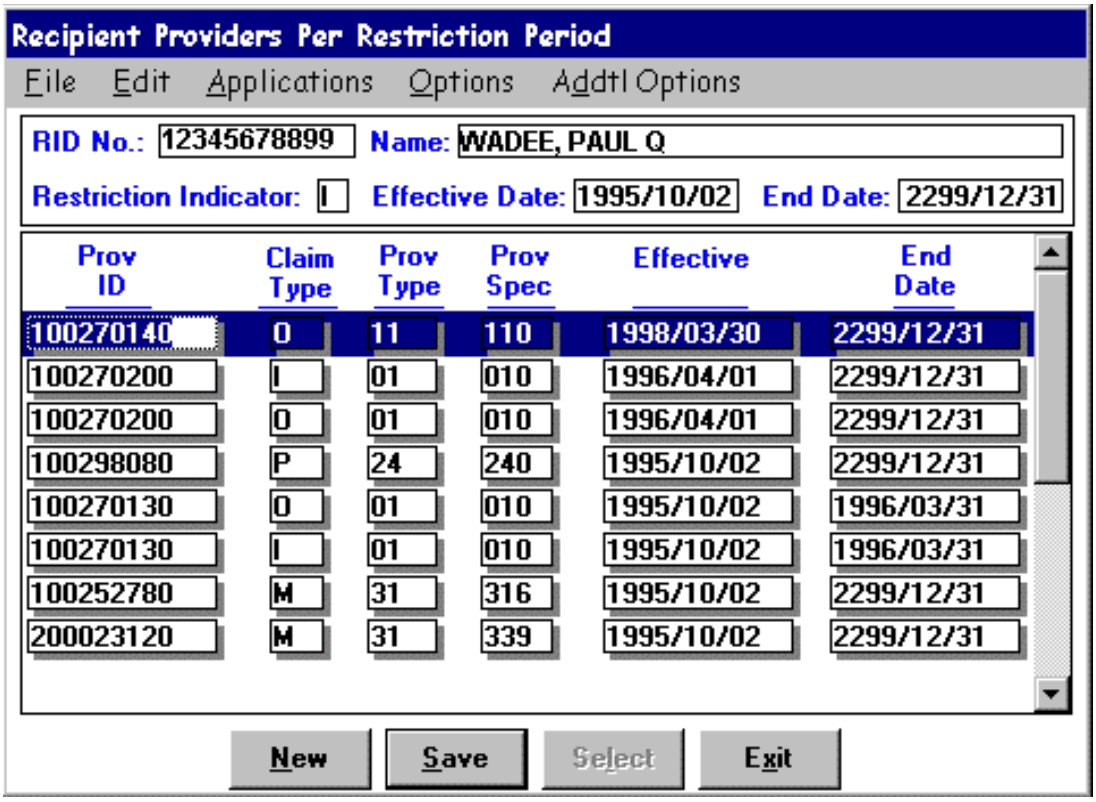

Figure 13.1 – Member Provider Per Restriction Period Window

File	Edit	Applications	Options		Addt'l Options
New	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Save	Paste	Claims	CSHCS		TPL Search/Resource
Delete	Cut	Financial	Eligibility	Standard	
Print		Managed Care		Replaced	
Exit		MARS	EOMB Request		
Audit		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
Exit Indiana*AIM*		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 13.2 - Member Providers Per Restriction Periods Window Menu Tree

Figure 13.2 is an illustration of a menu tree for the Member Providers Per Restriction Periods Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Providers Per Restriction Periods Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1 Click on the command or window option title.

2 Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member Providers Per Restriction Periods window, and exit Indiana*AIM*.

New – Allows user to add new information to the window.

Save – Saves entered information.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM* system.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage, Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

Names

PCNs

Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES.

Format – 12 numeric characters

Features – System generated

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's name in last, first format.

Format – 29 alphanumeric characters

Features – System generated

Edits – None

To Correct – N/a

Field Name: *RESTRICTION INDICATOR*

Description – Type of restriction, plugged from the related Member Restriction Period Segment used to access the Member Providers Per Restriction Period Window. Valid values are the following:

Field Name: *RESTRICTION INDICATOR*

Description – Type of Restriction.

Valid values are the following:

- *IN* – Locked in
- *OUT* – Locked out

Format – Three alphabetic characters

Features – None

Edits – 91006-Restriction Indicator Field is required!

To Correct –N/a

Field Name: *EFFECTIVE DATE*

Description – First date of service for which the member's claims will be subject to restriction, plugged from the related Member Restriction Period segment used to access the Member Providers Per Restriction Period window.

Format – CCYY/MM/DD

Features – System generated

Edits – None

To Correct – N/a

Field Name: *END DATE*

Description –Last date of service for which the member's claims will be subject to restriction, plugged from the related Member Restriction Period segment and used to access the Member Providers Per Restriction Period window.

Format – CCYY/MM/DD

Features – System generated

Edits – None

To Correct – N/a

Field Name: *MEMBER RESTRICTION PROVIDERS PROV ID*

Description – Provider's Medicaid identification number

Format – Nine numeric characters

Features – None

Edits – 5093 Provider ID must be nine characters!

To Correct – Verify entry. Provider ID must be nine characters.

91011 – Provider ID record not found – Please try again!

To Correct – Verify entry. Enter valid provider ID.

Field Name: *MEMBER RESTRICTION PROVIDERS CLAIM TYPE*

Description – Claim type of the provider for which the member is restricted

Format – One alphabetic character

Features – Drop-down list box. Double-click on valid values to populate data window. Valid values are displayed in Table 13.1.

Table 13.1 – Valid Values for Member Restriction Provider Claims

Code	Claim Type
A	UB92 INST XOVER CLAIMS
B	HCFA 1500 XOVER CLAIMS
C	UB92 OUTP XOVER CLAIMS
D	DENTAL CLAIMS
E	ENCOUNTER CLAIMS
F	FINANCIAL CLAIMS
H	HOME HEALTH CLAIMS
I	INPATIENT CLAIMS
L	NURSING HOME CLAIMS
M	HCFA 1500 CLAIMS
O	OUTPATIENT CLAIMS
P	PHARMACY CLAIMS

Edits – 91011 Claim type record not found –Please try again!

To Correct – Verify entry. Enter valid claim type code.

91006 Claim type is required!

To Correct – Enter a valid claim type.

Field Name: *MEMBER RESTRICTED PROVIDERS PROV TYPE*

Description – Provider type of the provider to which the member is restricted.

Format – Two numeric characters

Features – Drop-down list box. Double-click on valid values to populate data window

Edits – 91011 - Provider type record not found –Please try again!

To Correct – Verify entry. Enter a valid value or double-click on field to display valid values and double click on selected value to populate data field.

91029 - Must be numeric!

To Correct – Verify entry. Enter a valid value or double-click on field to display valid values and double click on selected value to populate data field.

4009 - Field must be two characters!

To Correct – Verify entry. Enter a valid value or double-click on field to display valid values and double-click on selected value to populate data field.

91006 - Provider type field required!

To Correct – Enter provider type.

Field Name: *MEMBER RESTRICTED PROVIDERS PROV SPEC*

Description – Provider specialty of the provider to which the member is restricted

Format – Three numeric characters

Features – Drop-down list box Double-click on valid values to populate data window

Edits – 91029. Must be numeric!

To Correct – Verify entry. Enter valid code or double-click on field to display valid values and double-click on selected value to populate data field.

4111 - Specialty must be three digits!

To Correct – Verify entry. Enter valid code or double-click on field to display valid values and double-click on selected value to populate data field.

Field Name: *MEMBER RESTRICTED PROVIDERS EFFECTIVE DATE*

Description – First date of service for which the member's claims will be subject to restriction for the provider.

Format – CCYY/MM/DD

Features – Queue system generated letters at save:

- Provider Restriction Notification Letter
- Restricted Utilization Letter

Edits – 91002 Date must be numeric!

To Correct – Verify entry. The date must be numeric.

8017 - Effective date must be greater than or equal to 1976/01/01

To Correct – Verify entry. The date must be greater than or equal to 01/01/1976.

91033 - Date must be less than 12/31/2299

To Correct – Verify entry. The date must be less than 12/31/2299.

91001 - Invalid Date (CCYYMMDD)!

To Correct – Verify entry. The date must be in the correct form.

_(*)_ Provider effective date must be greater than or equal to the restriction effective date.

To Correct – Verify entry. Provider effective date must be greater than or equal to the corresponding restriction effective date.

(*) edit number to be assigned

_(*)_ Provider effective date must be grater than or equal to the restriction end date

To Correct – Verify entry. Provider effective date must be less than equal to the corresponding restriction end date.

(*) edit number to be assigned

8036 - Effective date must proceed end date!

To Correct – Verify entry. Effective date must be less than the end date.

91003 - Date is required!

To Correct – Enter provider ID.

Field Name: *RECIPEINT RESTRICTED PROVIDERS END DATE*

Description –Last date of service for which the member's claims will be subject to restriction for the provider.

Format – CCYY/MM/DD

Features – Queue system generated letters at save:

Restricted Utilization Letter

Provider End Notification Letter

Edits – 91003 Date is required

To Correct – Enter provider ID.

_(*)_ No providers are selected for the related restriction period.

To Correct – Add corresponding provider information.

(*) edit number to be assigned.

91002 - Date must be numeric!

To Correct – Verify entry. The date must be numeric.

91033 - Date must be less than 12/31/2299.

To Correct – Verify entry. The date must be less than 12/31/2299.

4011 - Effective date must be less than or equal to the end date.

To Correct – Verify entry and rekey valid date. Effective date cannot be greater than end date.

91030 - Provider dates must be within the restriction period dates; date segment may not overlap.

To Correct – Verify entry and rekey valid date.

Other Messages: Edits

None

System Information

PBL – RECIP02.PBL

Window – W_RE_LOCKIN

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_LOCKIN

System Features

The **New** button allows the user to add a new member's restricted provider segment. The **Save** button saves the new segment or changes made to existing segments. The **Select** button allows the user to access the Member Restrictions Detail window for the highlighted segment. The **Exit** button returns the user to the previous window.

Section 14: Member Restriction Details Window

Introduction

The Member Restrictions Detail window is the entry point for inquiries about the specification of diagnosis, procedures, and drug codes to which the member is locked in or out.

Double-clicking on the Member's Restricted Providers Effective Date Segment to which the code range information applies accesses the Member Restrictions Detail window. The **New Diag**, **New Proc,** and **New Drug** buttons on the Member Restrictions Detail window allows the creation of new diagnosis, procedure, and drug segments by clicking the button, or pressing **Alt+D**, **Alt+P**, or **Alt+R** respectively. All previous segments shift down to displaying the new segment in the first segment position.

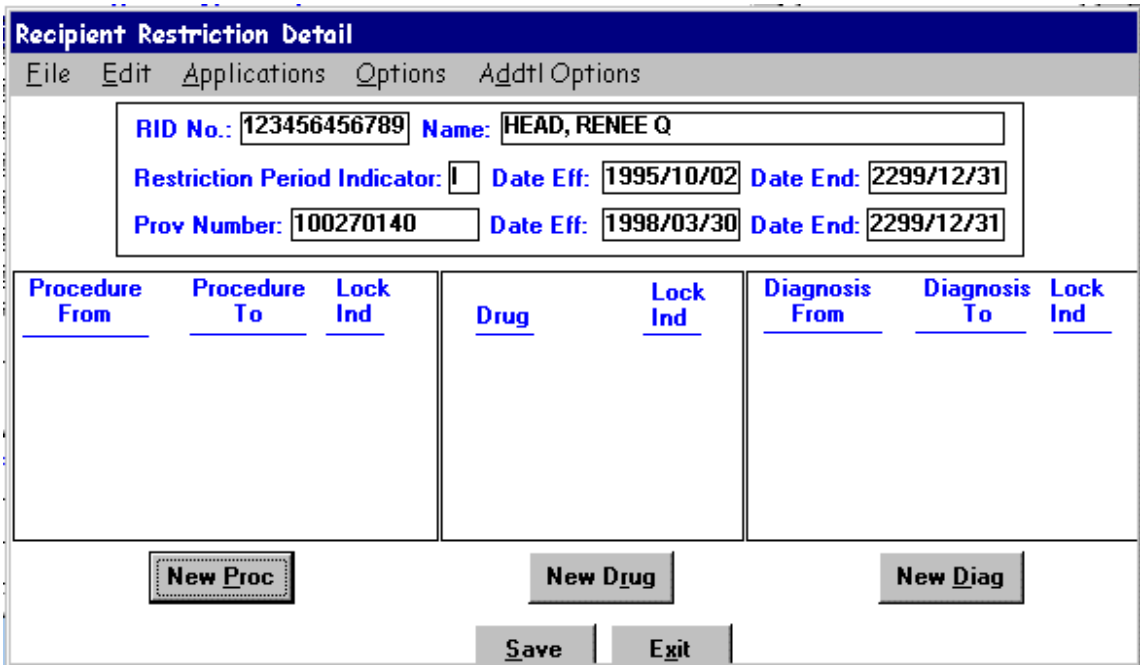

Figure 14.1 – Member Restriction Detail Window

File	Edit	Applications	Options		Addt'l Options
Save	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Delete	Paste	Claims	CSHCS		TPL Search/Resource
Print	Cut	Financial	Eligibility-	Standard	
Exit		Managed Care		Replaced	
Audit		MARS	EOMB Request		
Exit Indiana*AIM*		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 14.2 - Member Restriction Details Window Menu Tree

Figure 14.2 is an illustration of a menu tree for the Member Restriction Details Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Restriction Details Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1 Click on the command or window option title.

2 Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member Restriction Details window, and exit Indiana*AIM*.

Save – Saves entered information.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window for the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop down - list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings.

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop down - list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization.

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions.

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – System generated

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's name in last, first format

Format – 29 alphanumeric characters

Features – System generated

Edits – None

To Correct – N/A

Field Name: *RESTRICTION PERIOD INDICATOR*

Description – Type of restriction, plugged from the related Member Restriction Period Segment used to access the Member Providers Per Restriction Window. Valid values are the following:

- *IN* – Inclusive
- *OUT* – Exclusive

Format – One character alpha

Features – System generated

Edits – None

To Correct – N/a

Field Name: *EFFECTIVE DATE*

Description – First date of service for which the member's claims will be subject to restriction, plugged from the related Member Restriction Period segment used to access the Member Providers Per Restriction Period Window.

Format – CCYY/MM/DD

Features – System generated

Edits – None

To Correct – N/a

Field Name: *END DATE*

Description – Last date of service for which the member's claims will be subject to restriction, plugged from the related Member Restriction Period segment used to access the Member Providers Per Restriction Period Window.

Format – CCYY/MM/DD

Features – System generated

Edits – None

To Correct – N/a

Field Name: *PROV NUMBER*

Description – Provider's Indiana Health Coverage Program identification number, plugged from the related Member Providers Per Restriction Period segment and used to access the Member Restriction Detail window.

Format – Nine character numeric

Features – System generated

Edits – None

To Correct – N/a

Field Name: *EFFECTIVE DATE*

Description – First date of service for which the member's claims will be subject to restriction for the provider

Format – CCYY/MM/DD

Features – System generated

Edits – None

To Correct – N/a

Field Name: *END DATE*

Description – Last date of service for which the member's claims will be subject to restriction for the provider

Format – CCYY/MM/DD

Features – System generated

Edits – None

To Correct – N/a

Field Name: *RESTRICTED CODE RANGES PROCEDURE FROM*

Description – Lowest number in a sequential range of codes

Format – Five alphanumeric characters

Features – Drop-down list box, Double click on valid values to populate data window

Edits – 91034 must contain only A-Z

To Correct – Verify entry. Enter a valid procedure code, or click to display a drop-down list box of valid values and double-click to populate field.

91011 - Procedure form record not found. Please try again!

To Correct – Verify entry. Enter a valid procedure code or click to display drop-down list box of valid values and double-click to populate the field.

4105 - From Procedure must be less than or equal to the To Procedure

To Correct – Verify entry. From value must be less than or equal to value.

5071 - Restricted range overlap conflict!

To Correct – Verify entry. (Code being entered already exists in another segment). Codes cannot be defined more than once per restriction provider segment.

8029 - Procedure Code must have five characters.

To Correct – Verify entry. Please enter a five-character valid procedure code.

Field Name: *RESTRICTED RANGES PROCEDURES TO*

Description – The highest number in a sequential range of codes

Format – Five alphanumeric characters

Features – Drop down list box of valid values to populate data window.

Edits – 91034 must contain only A-Z

To Correct – Verify entry. Enter a valid procedure code or click to display a drop down list box of valid values and double-click to populate field.

91011 - Procedure form record not found. Please try again!

To Correct – Verify entry. Enter a valid procedure code or click to display a drop-down list box of valid values and double-click to populate field.

4105 - From Procedure must be less than or Equal to the To Procedure

To Correct – Verify entry. From value must be less than or equal to the value.

5071 - Restricted range overlap conflict!

To Correct – Verify entry. (Code being entered already exists in another segment). Codes cannot be defined more than once per Restriction Provider segment.

91006 - Indicator field is required!

To Correct – Enter valid indicator.

Field Name: *RESTRICTED CODE RANGES PROCEDURE LOCK IND*

Description – Indicates whether the restriction is inclusive to the code(s) displayed or exclusive of the code(s) displayed.

Format – Three alphabetic characters

Features – None

Edits – 4021 Restriction Indicator must be **O** or **I**

To Correct – Enter **I** or **O**

91006 - Field is required!

To Correct – Enter a procedure range.

Field Name: *RESTRICTED CODE RANGES DRUG*

Description – Drug code

Format – 11 numeric characters

Features – Drop-down list box, Double-click on valid values to populate the data window

Edits – 91029 must be numeric!

To Correct – Enter a valid drug code, or click to display a drop-down list box of valid values and double-click to populate the field.

8016 - Duplicate found. Please rekey!

To Correct – Verify entry (code being entered already exists in another segment.) Codes cannot be defined more than once per Restriction Provider segment.

8044 - Drug code must be 11 characters in length!

To Correct – Verify entry. Key a valid 11-character drug code.

91011 - Drug Code Record not found. Please try again!

To Correct – Verify entry. Key a valid 11-character drug code.

Field Name: *RESTRICTED CODE RANGES DRUG LOCK IND*

Description – Indicates whether the restriction is inclusive to the code displayed or exclusive of the code displayed. Valid values are:

- *IN* – Inclusive
- *OUT* – Exclusive

Format – Three alphabetic characters

Features – None

Edits – 4021 Restriction Indicator must be **I** or **O**

To Correct – Enter **I** or **O**

91006 - Field is required!

To Correct – Enter a drug code.

Field Name: *RESTRICTED CODE RANGES DIAGNOSIS FROM*

Description – Lowest number in a sequential range of diagnosis code

Format – Five character numeric

Features – Drop-down list box, Double click on valid values to populate the data window.

Edits – 8018 Diagnosis Code must be greater than or equal to three characters long!

To Correct – Enter a valid diagnosis code at least four characters in length, or click to display a drop-down list box of valid values and double-click to populate field.

91029 - must be numeric!

To Correct – Enter a valid diagnosis code at least four characters in length, or click to display a drop-down list box of valid values and double-click to populate the field.

4104 - From Diagnosis must be less than or equal to the To Diagnosis

To Correct – Verify entry. From value must be less than or equal to the value.

5071 - Diagnosis date and code range overlap existing segment!

To Correct – Verify entry (code being entered already exists in another segment). Codes cannot be defined more than once per Restriction Provider segment.

91011 - Diagnosis from record not found. Please try again!

To Correct – Verify entry. Enter a valid diagnosis code at least four characters in length, or click to display a drop-down list box of values and double-click to populate the field.

Field Name: *RESTRICTED CODE RANGES DIAGNOSIS TO*

Description – Highest number in a sequential range of diagnosis codes

Format – Five numeric characters

Features – Drop-down list box, Double click on valid values to populate data window

Edits – 8018 Diagnosis code must be greater than or equal to three characters long!

To Correct – Enter a valid diagnosis code at least four characters in length, or click to display a drop-down list box of valid values and double-click to populate the field.

91029 - Must be numeric!

To Correct – Enter a valid diagnosis code at least four characters in length, or click to display a drop-down list box of valid values and double-click to populate the field.

91011 - Diagnosis from record not found. Please try again!

To Correct – Verify entry. Enter a valid diagnosis code at least four characters in length, or click to display a drop down - list box of values and double-click to populate the field.

4104 - From Diagnosis must be less than or equal to the To Diagnosis

To Correct – Verify entry. From value must be less than or equal to value.

5071 - Diagnosis date and code range overlap existing segment!

To Correct – Verify entry (code being entered already exists in another segment). Codes cannot be defined more than once per Restriction Provider segment.

91011 - Record not found. Please try again!

To Correct – Verify entry. Enter a valid diagnosis code at least four characters in length, or click to display a drop-down list box of values and double-click to populate the field.

Field Name: *RESTRICTED CODE RANGE DIAGNOSIS LOCK IND*

Description – Indicates whether the restriction is inclusive to the code(s) displayed or exclusive of the code(s) displayed.

Format – Three alphabetic characters

Features – None

Edits – 4021 Restriction Indicator must be **I** or **O**!

To Correct – Enter **I** or **O**.

91006 - Field is required!

To Correct – Enter a diagnosis range.

Other Messages/Edits

None

System Information

PBL – RECIP02.PBL

Window – W_RE_LOCK_RESTRICTIONS

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_LOCK_DIAG_RNG

DW_RE_LOCK_PROC_RNG

DW_RE_LOCK_DRUG

System Features

The **New Proc** button allows the user to add a new Procedure Restricted segment. The **New Drug** button allows the user to add a New Restricted drug segment. The **New Diag** button allows the user to add a new Diagnosis segment. The **Save** button saves the new segments or changes made to existing segments. The **Exit** button returns the user to the previous window.

Section 15: Restriction Member Notification Letters Window

Introduction

EDS use the Restriction Member Notification Letter window to access all Members Notification letters queued during Member Restriction segment update. The Restriction Member Notification Letter window is accessed through the Member Base window by clicking **LOCKIN** and **LOCK NOTIFICATION**, or by pressing **Alt+O**, **Shift+K**, and **Shift+N**. The user highlights the specific letter to be printed, clicks **Print**, or presses **Alt+P** to immediately print the highlighted letter on the local printer. The **Print All** button is used to send all letters in queue immediately to the local printer. If the user does not elect to print the letters in queue right away, the letters are automatically sent to print overnight.

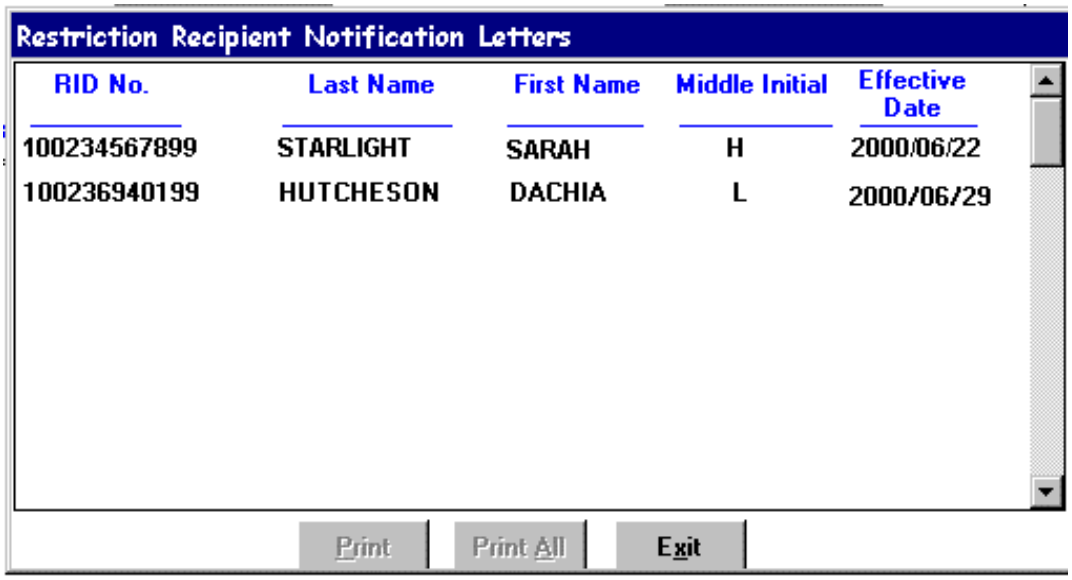

Figure 15.1 – Restriction Member Notification Letters

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – System generated

Edits – None

To Correct – N/a

Field Name: *LAST NAME*

Description – Member's last name

Format – Alphanumeric

Features – System generated

Edits – None

To Correct – N/a

Field Name: *FIRST NAME*

Description – Member's first name

Format – Alphanumeric

Features – System generated

Edits – None

To Correct – N/a

Field Name: *MIDDLE INITIAL*

Description – Member's middle initial

Format – Alphanumeric

Features – System generated

Edits – None

To Correct – N/a

Field Name: *EFFECTIVE DATE*

Description – First date of service for which the member's claims will be subject to restriction

Format – CCYY/MM/DD

Features – System generated

Edits – None

To Correct – N/a

System Information

PBL – RECIP02.PBL

Window – W_RE_LOCK_LETTER1

Menu – NONE

Data Windows – DW_RE_LOCK_LETTER1

Section 16: Provider Restriction Notification Letters Window

Introduction

EDS uses the Provider Restriction Notification Letter window to access all provider notification letters queued during Member Restriction segment update. The Provider Restriction Notification Letter window is accessed through the Member Base window by clicking **LOCKIN** and **LOCK PROV NOTIFICATION**, or by pressing **Alt+O**, **Shift+K**, and **Shift+P**. The user will highlight the specific letter to be printed, click the **Print** button, or key **Alt+P** to immediately print the highlighted letter on the local printer. The **Print All** button is used to send all letters in the queue immediately to the local printer. If the user does not elect to print the letters in queue right away, the letters are automatically sent to print overnight.

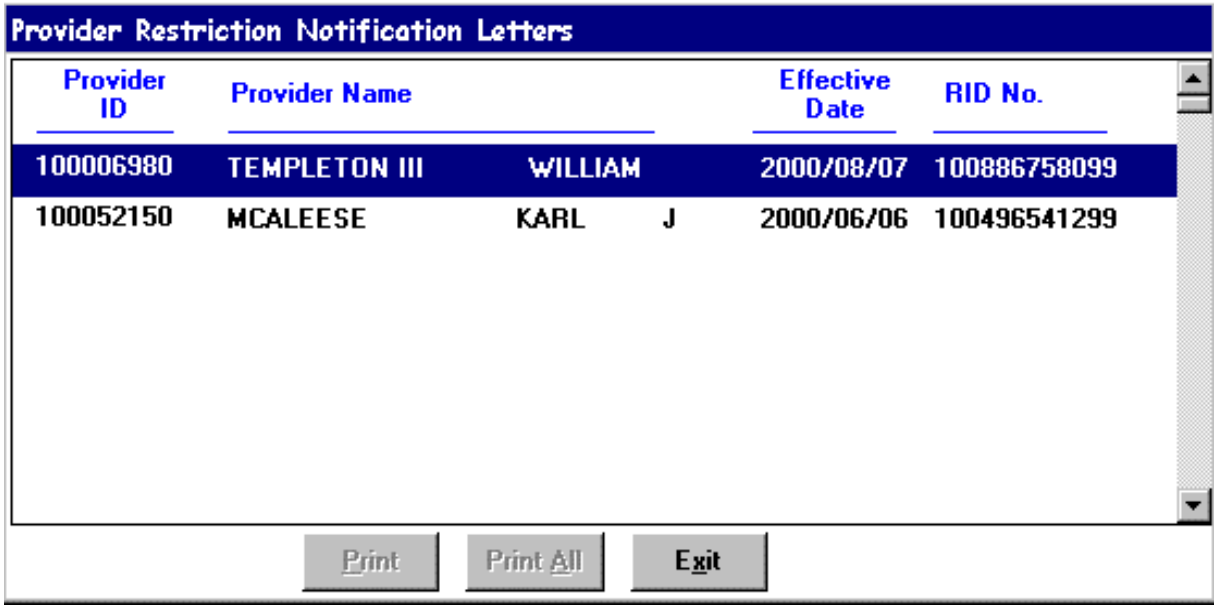

Figure 16.1 – Provider Restriction Notification Letters Window

Field Information

Field Name: *PROVIDER ID*

Description – Provider's IHCP ID

Format – Nine numeric characters

Features – System generated

Edits – None

To Correct – N/a

Field Name: *PROVIDER NAME*

Description – Provider's name

Format – Alphanumeric (last, first)

Features – System generated

Edits – None

To Correct – N/a

Field Name: *EFFECTIVE DATE*

Description – First date of service for which the provider is designated by the member as primary provider of IHCP services

Format – CCYY/MM/DD

Features – System generated

Edits – None

To Correct – N/a

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – System generated

Edits – None

To Correct – N/a

System Information

PBL – RECIP02.PBL

Window – W_RE_LOCK_LETTER2

Menu – NONE

Data Windows – DW_RE_LOCK_LETTER2

Section 17: Provider End Notification Letters Window

Introduction

EDS uses the Provider End Notification Letter window to access all provider selection letters queued during Member Restriction segment update. The Provider End Notification Letter window is accessed through the Member Base window by clicking **LOCKIN** and **LOCK PROV END NOTIFICATION**, or by pressing **Alt+O**, **Shift+K**, and **Shift+E**. The user highlights the specific letter to be printed, clicks the **Print** button, or presses **Alt+P** to immediately print the highlighted letter on the local printer. The **Print All** button is used to send all letters in queue immediately to the local printer. If the user does not elect to print the letters in queue right away, the letters are automatically sent to print overnight.

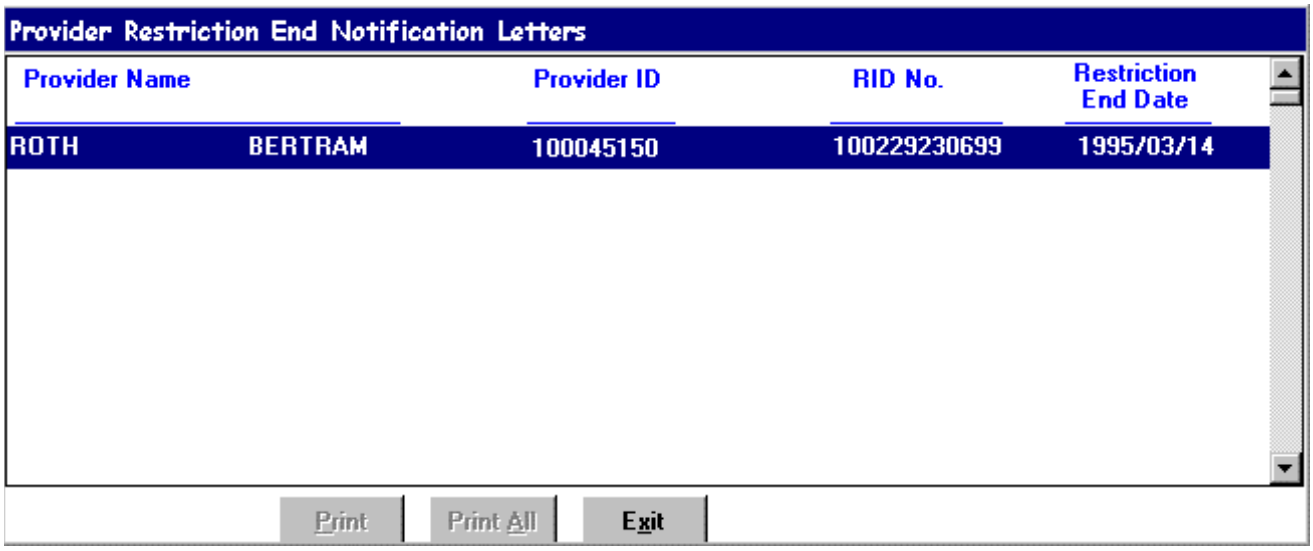

Figure 17.1 – Provider Restriction End Notification Letters Window

Field Information

Field Name: *PROVIDER ID*

Description – Provider's IHCP ID

Format – Nine numeric characters

Features – System generated

Edits – None

To Correct – N/a

Field Name: *PROVIDER NAME*

Description – Provider's name

Format – Alphanumeric (last, first)

Features – System generated

Edits – None

To Correct – N/a

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – System generated

Edits – None

To Correct – N/a

Field Name: *RESTRICTION END DATE*

Description – Last date of service for which the provider is designated by the member as primary provider of IHCP services

Format – 12 numeric characters

Features – System generated

Edits – None

To Correct – N/a

System Information

PBL – RECIP02.PBL

Window – W_RE_LOCK_LETTER4

Menu – NONE

Data Windows – DW_RE_LOCK_LETTER4

Section 18: Restricted Utilization Window

Introduction

EDS uses the Restricted Utilization window to access all provider change letters queued during Member's Restricted Providers segment update. The Restricted Utilization window is accessed through the Member Base window by clicking **LOCKIN** and **LOCK UTILIZATION**, or by pressing **Alt+O**, **Shift+K**, **Shift+U**. The user highlights the specific letter to be printed, click the **Print** button, or presses **Alt+P** to immediately print the highlighted letter on the local printer. The **Print All** button is used to send all letters in queue immediately to the local printer. If the user does not elect to print the letters in queue right away, the letters are automatically sent to print overnight.

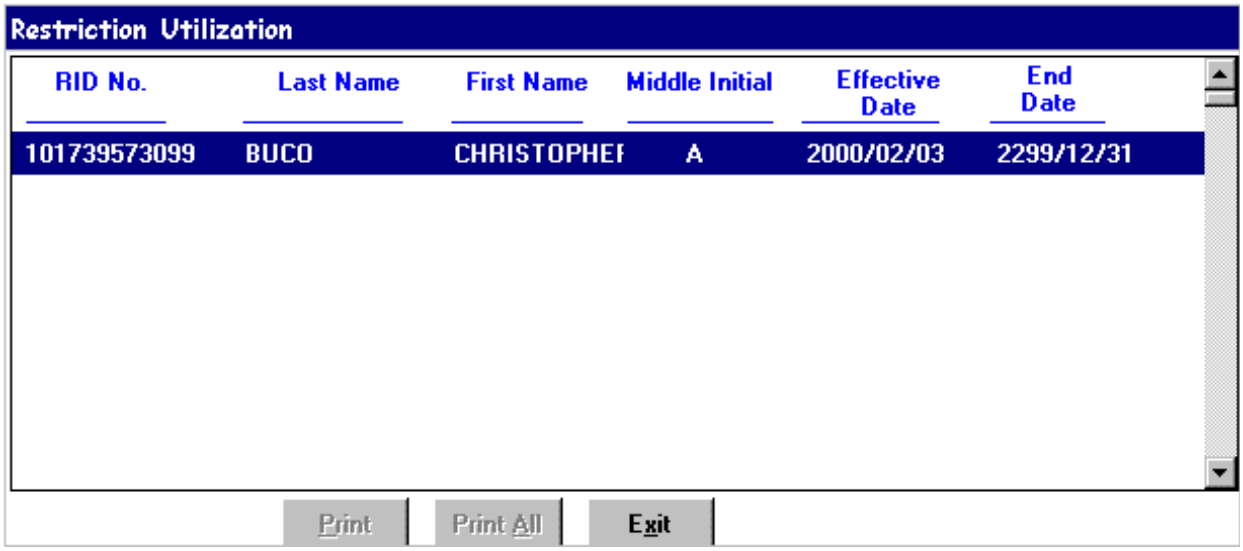

Figure 18.1 – Restriction Utilization Window

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – System generated

Edits – None

To Correct – N/a

Field Name: LAST NAME

Description – Member's last name

Format – Alphanumeric

Features – System generated

Edits – None

To Correct – N/a

Field Name: *FIRST NAME*

Description – Member's first name

Format – Alphanumeric

Features – System generated

Edits – None

To Correct – N/a

Field Name: *MIDDLE INITIAL*

Description – Member's middle initial

Format – Alphanumeric

Features – System generated

Edits – None

To Correct – N/a

Field Name: ***EFFECTIVE DATE***

Description – Effective date of the provider segment added

Format – CCYY/MM/DD

Features – System generated

Edits – None

To Correct – N/a

Field Name: ***END DATE***

Description – End date of the provider segment added

Format – CCYY/MM/DD

Features – System generated

Features – System generated

Edits – None

To Correct – N/a

System Information

PBL – RECIP02.PBL

Window – W_RE_LOCK_LETTER3

Menu – NONE

Data Windows – DW_RE_LOCK_LETTER3

Section 19: Periodicity and Screening Schedule Window

Introduction

The Periodicity and Screening Schedule is used to control all automated tracking and notifications processes by establishing the frequency with which reminder notices are sent and screenings are performed. The Periodicity and Screening Schedule is accessed through the Member Base window by clicking on the **EPSDT**, **PERIODICITY SCHEDULES**, and **REGULAR SCREENING**, or by pressing **Alt+O**, **Shift+E**, **Shift+P**, and arrowing down to **REGULAR SCREENING**.

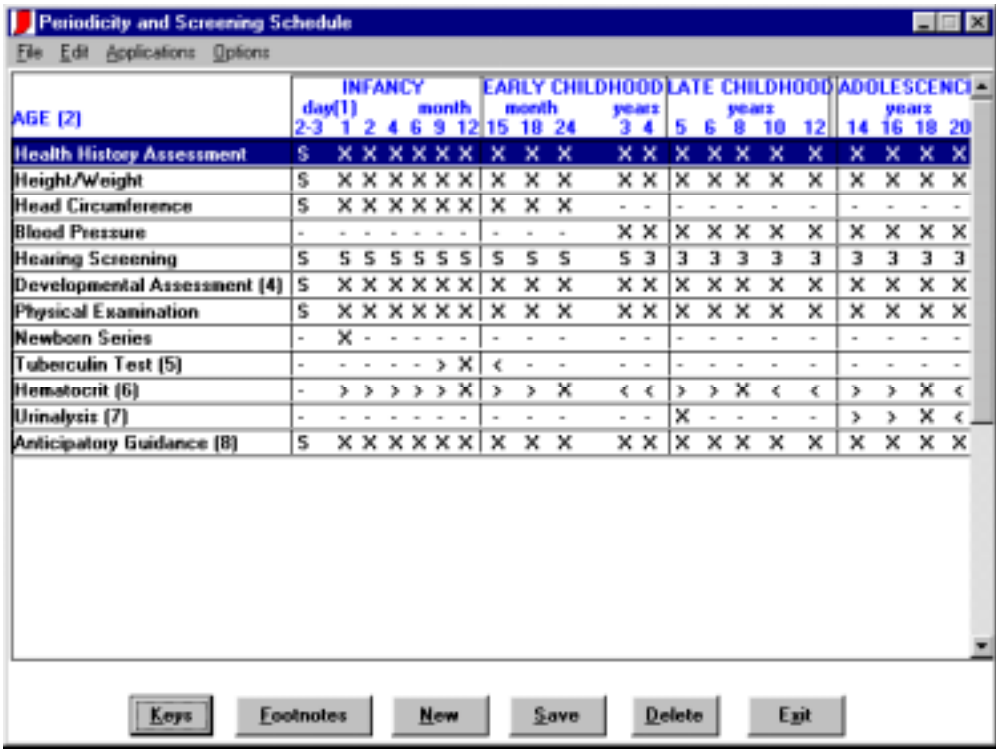

Figure 19.1 Periodicity and Screening Schedule Window

Field Information

Field Name: *SCREENING ROW*

Description – A description of all EPSDT screening types (including footnotes) with valid values to include the following:

- AGE (3)
- MEASURE (initial/interval)
- MEASURE (height/weight)
- MEASURE (Head Circumference)
- MEASURE (Blood Pressure)
- SENSORY SCREEN (Vision)
- SENSORY SCREEN (Hearing)
- DEVELOP/BEHAVIORAL (5)
- PHYSICAL EXAMINATION (6)
- PROC (7) Heredity/Metabolic (8)
- PROC (7) Immunization (9)
- PROC (7) Tuberculin Test (10)
- PROC (7) Hematocrit (11)
- PROC (7) Urinalysis (12)
- ANTICIPATORY GUIDANC (13)

**Please refer to attachment (I) for footnote definitions.*

Format – Alphanumeric

Features – None

Edits – 4114 - EPSDT screening description is missing.

To Correct – Please enter EPSDT screening description

Field Name: *SCREENING PERIOD COLUMNS*

Description – A description of all EPSDT Screening Period Columns with valid values to include the following:

- Infancy (day: 2-3 / month: 1, 2, 4, 6, 9, 12)
- Early Childhood (month: 15, 18, 24, / Years: 3 and 4)
- Late Childhood (Years: 5, 6, 8, 10, and 12)
- Adolescence (Years: 14, 16, 18, and 20)

Format – N/a

Features – Protected. Displays titles of screening periods

Edits – None

To Correct – N/a

Field Name: *SCREENING INDICATORS*

Description – Field's valid values include: X, S, C, -, 3, 4, >, and <.

X – To be performed
S – Subjective, by history
C – Refer to footnote (c) (Note: footnote for vision referral)
- – Not applicable
3 – Refer to footnote 3 (Note: bring up to date)
4 – Refer to footnote 4 (Note: footnote for hearing screen)
> – Denotes "range" a screening may be performed pointing towards suggested screening time period.
< – Denotes "range" a screening may be performed pointing back to the suggested screening time period.

Format – One alphanumeric character

Features – None

Edits – 4113 - Valid values are X, S, C, -, 3, 4, >, and <.

To Correct – Verify entry. Valid values are X, S, C, -, 3, 4, >, and <.

System Information

PBL – RECIP04.PBL

Window – W_RE_EPSDT_SCREENING_PERIODICITY

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_EPSDT_SCREENING_PERIODICITY

DW_RE_EPSDT_SCREENING_XREF

System Features

Keys – Click once to access the Periodicity and Screening Key window that lists and defines the valid indicators used on the Periodicity and Screening Schedule window.

Footnotes – Click once to access the Periodicity and Screening Footnotes window that lists and defines the footnotes used on the Periodicity and Screening Schedule window.

New – Click once to add a new screening row to the Periodicity and Screening Schedule window.

Save – Click once to save changes made to Periodicity and Screening Schedule.

Delete – Click once to delete the highlighted text.

Exit – Click once to exit the periodicity and Screening Schedule window and return to the previous window.

Section 20: Supplement to the American Academy of Pediatrics Periodicity Schedule Window

Introduction:

The Supplement to the American Academy of Pediatrics Periodicity Schedule is used to determine when a member is due for immunizations and additional test screenings. The Supplement to the American Academy of Pediatrics Periodicity Schedule is accessed through the Member Base window by clicking **EPSDT, PERIODICITY SCHEDULES**, and **REGULAR SUPPLEMENT**, or by pressing **Alt+O**, **Shift+E**, **Shift+P**, and arrowing down to **REGULAR SUPPLEMENT**.

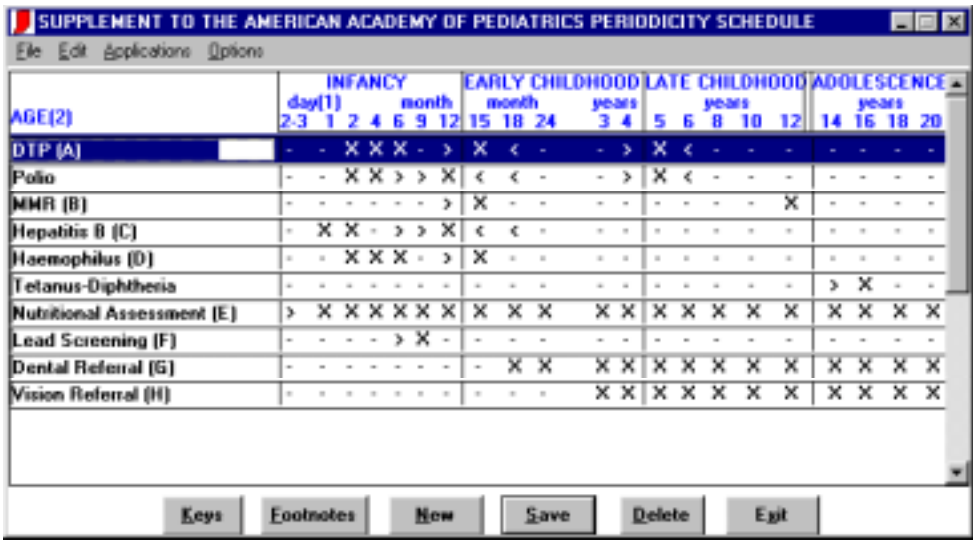

Figure 20.1 – Supplement to the American Academy of Pediatrics Periodicity Schedule Window

Field Information

Field Name: *IMMUNIZATIONS AND ADDITIONAL SCREENINGS ROW*

Description – A description of all EPSDT screenings with valid values that include the following:

- AGE (3)
- DPT
- Polio
- MMR
- Hepatitis B
- Haemophilus
- Tetanus - Diphtheria
- Nutritional Assessment (a)
- Lead Screening
- Dental Ref. (b)
- Vision Ref. (c)
- Dental Observation

**Please refer to attachment (I) for footnote definitions.*

Format – N/a

Features – None

Edits – 4114 - EPSDT screening description is missing

To Correct – Please enter EPSDT screening description

Field Name: *IMMUNIZATIONS AND ADDITIONAL SCREENINGS PERIOD COLUMNS*

Description – A description of all EPSDT immunizations period columns with valid values to include the following:

- Infancy (day: 2-3 / month: 1, 2, 4, 6, 9, 12)
- Early Childhood (month: 15, 18, 24, / Years: 3 and 4)
- Late Childhood (Years: 5, 6, 8, 10, and 12)
- Adolescence (Years: 14, 16, 18, and 20)

Format – Alphanumeric

Features – Protected. Displays titles of screening periods.

Edits – None

To Correct – N/a

Field Name: *IMMUNIZATION AND ADDITIONAL SCREENING INDICATORS*

Description – This field's valid values are to include: X, S, C, -, 3, 4, >, and <.

X – to be performed

S – Subjective, by history

C – Refer to footnote (c) (Note: footnote for vision referral)

- – Not applicable

3 – Refer to footnote 3 (Note: bring up to date)

4 – Refer to footnote 4 (Note: footnote for hearing screen)

> – Denotes "range" a screening may be performed pointing towards suggested screening time period

< – Denotes "range" a screening may be performed pointing back to the suggested screening time period

Format – One Character Alphanumeric

Features – None

Edits – 4113 - Valid values are X, S, C, -, 3, 4, >, and <.

To Correct – Verify entry. Valid values are X, S, C, -, 3, 4, >, and <.

System Information

PBL – RECIP04.PBL

Window – W_RE_EPSDT_SCREENING_PERIODICITY

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_EPSDT_SCREENING_PERIODICITY

DW_RE_EPSDT_SCREENING_XREF

System Features

Keys – Click once to access the Periodicity and Screening Key window that lists and defines the valid indicators used on the Periodicity and Screening Schedule window.

Footnotes – Click once to access the Periodicity and Screening Footnotes window that lists and defines the footnotes used on the Periodicity Schedule windows.

New – Click once to add a new screening row.

Save – Click once to save changes made to Periodicity Schedule windows.

Delete – Click once to delete the highlighted text.

Exit – Click once to exit the Supplement to the American Academy of Pediatrics Periodicity Schedule window and return to the previous window.

Section 21: Member EPSDT Screenings

Introduction

The EPSDT Screenings Window is used by IFSSA to view screening claim history and immunization claim history performed for EPSDT, eligible members. The EPSDT Screenings window is accessed through the Member Base window by clicking **EPSDT** and **RECIP SCREENINGS**, or by pressing **Alt+O**, **Shift+E**, and **Shift+R**.

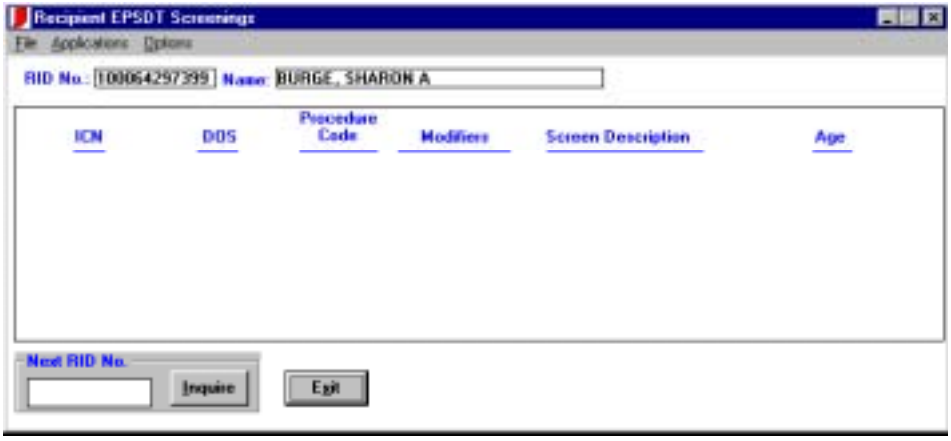

Figure 21.1 – Member EPSDT Screenings Window

File	Applications	Options	
Print	Adhoc Reporting	Base	
Exit	Claims	CSHCS	
Exit Indiana*AIM*	Financial	Eligibility-	Standard
	Managed Care		Replaced
	MARS	EOMB Request	
	Prior Authorization	EPSDT-	Abnormalities w/modifiers
	Provider		Abnormalities w/out modifiers
	Member		Missed appointment schedules
	Reference		Periodicity Schedules-
	Security		Accelerated Schd 2 to 6
	SURS		Accelerated Schd 7 to 17
	Third Party Liability		Accelerated Schd 18 and over
	System Parms		Regular Screening
	Research/Project Tracking System		Regular Supplement
			Recip abnormalities
			Recip notices
			Recip screenings
		ID Cards	
		Lock-in-	Lockin Base
			Lock Notification
			Lock Prov Notification
			Lock Prov End Notification
			Lock Utilization
		LOC	
		Medicare-	Billing A Mismatches
			Billing B Mismatches
			Buyin Coverage
			Dual Aid Eligibility
			Medicare Coverage
			Override
			Part A Billing
			Part B Billing
			Premium 150
			Premium S15
			Premium S15 Exceptions
			Premium 150 Exceptions
		Patient Liab	
		Potential MC Recip	
		Previous-	Addresses
			Names
			PCNs
		PMP Assignment	
		Recip Mother RID	
		Redetermination Date	
		Search	
		Spenddown	
		590 Search	
		Suspended ICES Dupe	
		Link History	
		Mgd Care Rate Cell	
		Newborn PMP History	

Figure 21.2 - Member EPSDT Screenings Window Menu Tree

Figure 21.2 is an illustration of a menu tree for the Member EPSDT Screenings Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member EPSDT Screenings Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member EPSDT Screenings window, and exit Indiana*AIM*.

Print – Allows the user to print the screen, top window or, data window.

Exit – Returns the user to previous window.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM* system.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility, dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers

- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings.

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The - drop down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By the **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Field Information

Field Name: *RID No.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's name

Format – 29 alphabetic characters with special character options (space, hyphen, and apostrophe)

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name: *ICN*

Description –Internal control number assigned to the claim

Format – 13 alphabetic characters

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name: *FIRST DOS*

Description – From date of SERVICE listed on the detail

Format – CCYYMMDD

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name*: PROCEDURE CODE*

Description – EPSDT procedure code billed on the detail

Format – Five alphabetic characters

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name: *MODIFIER*

Description – Modifier code billed for the procedure.

Format – Two alphabetic characters

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name: *SCREEN DESCRIPTION*

Description – Description of the screening performed.

Format – 30 alphabetic characters

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name: *AGE*

Description – Age of EPSDT member on the date of the screening

Format – 11 alphanumeric characters

Features – Protected. Display only.

Edits – None

To Correct – N/a

System Information

PBL – RECIP04.PBL

Window – W_RE_EPSDT_SCREENINGS

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_EPSDT_SCREENINGS

System Features

Click **EXIT** to exit from the Member EPSDT Screenings window and return to the previous window.

Section 22: Periodicity and Screening Footnotes Window

Introduction

The Periodicity and Screening Footnotes window is used as a reference for the footnotes noted on the Periodicity and Screening Schedule and the Supplement to the American Academy of Pediatrics (AAP) Periodicity Schedule. The Periodicity and Screening Footnotes window is accessed through the Member Base window by clicking **EPSDT**, **PERIODICITY SCHEDULES, REGULAR SCREENING**, or by pressing **ALT+O**, **Alt+E**, and **Alt+P**, then arrowing down to the **REGULAR SCREENING** option. Then click FOOTNOTES on the Periodicity and Screening Footnotes Screen, or press **Alt+F**. The footnotes are as follows:

Table 22.1 – Valid Footnotes for Periodicity and Screening Window

Code	Definition
1.	For newborns discharged in 24 hours or less after delivery
2.	If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time. Adolescent-related issues, such as psychosocial, emotional, substance usage, and reproductive health, may necessitate more frequent health supervision.
3.	The EPSDT screen includes a hearing test using objective measures. Providers who do not have equipment to give an objective hearing test are to refer patients to the appropriate specialist for screening. Hearing tests are given by the Department of Education in grades 1, 4, 7, and 10. Several schools also test kindergarten children. These screening efforts should not be duplicated unless the child is "at risk" and the situation warrants rescreening. Using an audiometer for testing children younger than four (4) years of age is left to the individual practice.
4.	Developmental assessment is to be accomplished by doing a health history assessment and an appropriate physical examination. Specific objective development testing is to be conducted and billed separately when an abnormality is suspected.
5.	Children is high-risk populations should be tested for tuberculosis in the first year.

(Continued)

Table 22.1 – Valid Footnotes for Periodicity and Screening Window

Code	Definition
6.	One (1) hematocrit or hemoglobin test is required during each time period (once during infancy, once during early childhood, once during late childhood, and once during adolescence). Performance of additional tests is left to the individual practice experience.
7.	Urinalysis is required at five (5) years of age and at least once during adolescence. The American Academy of Pediatrics recommends a urinalysis during each time period. Performance of additional tests is left to the individual practice experience. Bring up to date if not done at five (5) years of age.
8.	Appropriate preventive health counseling should be an integral part of each visit.
Supplement To The AAP Periodicity Schedule	
(A)	The 4th dose of DTP should be given 6 to 12 months after the 3rd dose of DTP and may be given as early as 12 months of age, provided that the interval between doses 3 and 4 is at least 6 months and DTP is given. DTP should not be given at or after the 7th birthday. **DTAP is not currently licensed for use in children younger than 15 months. DTAP should not be given at or after the 7th birthday.**
(B)	MMR should be given at 12 months of age in high-risk areas. Tuberculin testing may be done at the same visit.
(C)	Infants of mothers who tested seropositive for Hepatitis (HbsAg+) must also receive Hepatitis B Immune Globulin (HBIG) at or shortly after the first dose, a second hepatitis B vaccine dose at 1 month, and a third hepatitis B vaccine injection at 6 months of age. Physicians may decide that infants of mothers who tested seronegative begin the three-dose schedule after the baby has left the hospital.
(D)	Check with individual manufacturer's instructions for administration of Haemophilus Influenza Type B (HIB) recommendations. Combination DTP/HIB may be used when both shots are scheduled simultaneously.
(E)	(Optional) All children under five (5) years of age, pregnant women, postpartum women up to six (6) months, and postpartum women who are breast-feeding up to one (1) year, may be referred to WIC. To locate the nearest site for this nutrition program, those referred should call the Family Wellness Helpline at 1-800-433-0746.

(Continued)

Table 22.1 – Valid Footnotes for Periodicity and Screening Window

Code	Definition
(F)	Blood lead screening should initially be done in infancy between six (6) to eight (8) months. Subsequent testing may be done annually up to six (6) years of age. High risk groups should be tested at every visit through six (6) years of age. Bring up to date if not done at six (6) to eight (8) months.
(G)	Providers are responsible for referring children for dental services beginning at eighteen (18) months of age unless a problem starts earlier. The Indiana Dental Association recommends check ups every six (6) months.
(H)	Providers are responsible for referring children for vision services beginning at three (3) years of age.
Accelerated Periodicity Schedule	
(a)	Interruption of the recommended schedule with a delay between doses does not interfere with the final immunity achieved, nor does it necessitate starting the series over again, regardless of the length of time elapsed.
(b)	If the third dose of polio vaccine was received before the fourth birthday, a fourth dose may be given at school entry. Fourth dose is not needed if the third dose was given after fourth birthday.
(c)	Two doses of MMR vaccine are now recommended. Two doses of Measles (MMR preferred) should be administered by age 11-12. The second dose of MMR may be administered thirty (30) days after the first dose. MMR vaccines should not be given to pregnant females. For post-pubertal females in need of measles, mumps, or rubella vaccines, reasonable precautions should be used: 1) Asking her if she is pregnant, 2) Excluding those who say they are, and 3) Explaining the theoretical risks of the vaccine to the others and counseling them not to become pregnant for three months after the vaccination. It is not recommended that females sign a separate waiver other than the appropriate Important Information Statement or Vaccine Information Pamphlet. Vaccine containing rubella is highly indicated for children who may be in contact with susceptible pregnant women – the shed virus is not communicable. MMR-2 is especially recommended for all new entering college students and may be administered at any time thirty days after the first dose.

(Continued)

Table 22.1 – Valid Footnotes for Periodicity and Screening Window

Code	Definition
(d)	If the first dose of HIB was given after 15 months of age, no additional doses are recommended. For healthy children, do not administer after age five (59 months of age). Refer to ACIP recommendations.
(e)	If the fourth dose of DTP was administered after the fourth birthday, there is no need to administer the fifth dose.

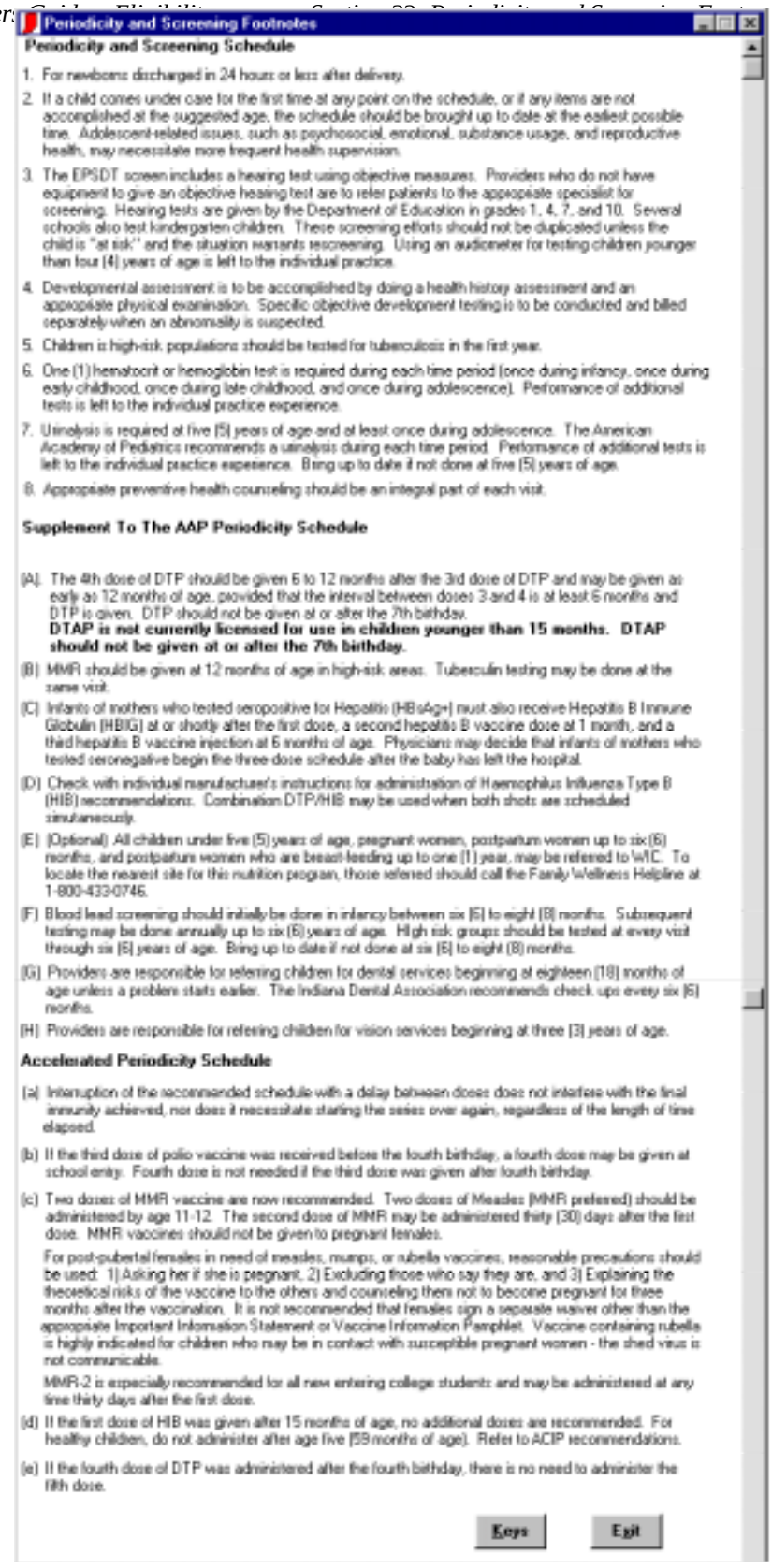

Figure 22.1 – Periodicity and Screening Footnotes Window

System Information

PBL – RECIP04.PBL

Window – W_RE_EPSDT_SCREENING_PERIODICITY

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_EPSDT_SCREENING_PERIODICITY

DW_RE_EPSDT_SCREENING_XREF

System Features

Keys – Click once to access the Periodicity and Screening Key window that lists and defines the valid indicators used on the Periodicity and Screening Schedule window.

Exit – Click once to exit the Periodicity and Screening Footnotes window and return to the previous window.

The scrolling bar located on the left of the screen allows the user to scroll up and down through the document.

Section 23: Periodicity and Screening Key Window

Introduction

The Periodicity and Screening Keys window is used as a reference for the valid values noted on the Periodicity and Screening Schedule and the Supplement to the American Academy of Pediatrics (AAP) Periodicity Schedule. The Periodicity and Screening Keys window is accessed through the Periodicity and Screening Schedule window by clicking **Keys**, or by pressing **Alt+K**. Valid values are the following:

- *X* – to be performed
- *S* – subjective, by history
- *C* – Refer to footnote (c) (Note: footnote for vision referral)
- **-** – Not applicable
- *3* – Refer to footnote 3 (Note: bring up to date)
- *4* – Refer to footnote 4 (Note: footnote for hearing screen)
- > – Denotes "range" a screening may be performed pointing towards suggested screening time period
- < – Denotes "range" a screening may be performed pointing back to the suggested screening time period.

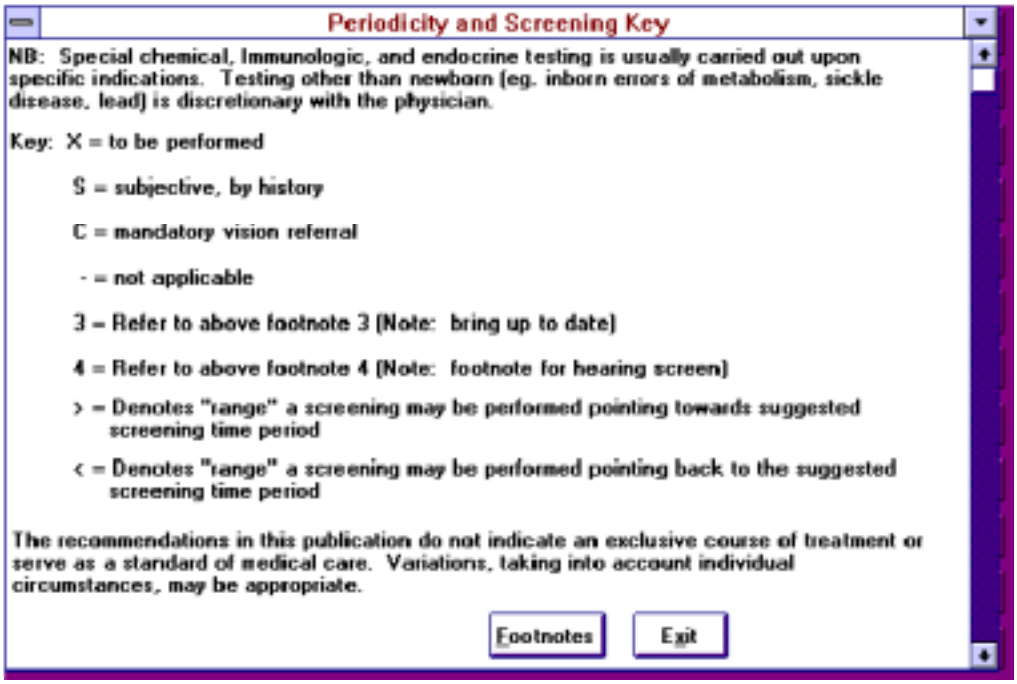

Figure 23.1 – Periodicity and Screening Key Window

System Information

PBL – RECIP04.PBL

Window – W_RE_EPSDT_SCREENING_PERIODICITY

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_EPSDT_SCREENING_PERIODICITY

DW_RE_EPSDT_SCREENING_XREF

System Features

Footnotes – Click once to access the Periodicity and Screening Footnotes window that lists and defines the footnotes used on the Periodicity Schedule windows. The footnotes are displayed in Table 23.1.

Table 23.1 – Footnote Codes

Code	Definition
1.	For newborns discharged in 24 hours or less after delivery
2.	If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time. Adolescent-related issues, such as psychosocial, emotional, substance usage, and reproductive health, may necessitate more frequent health supervision.
3.	The EPSDT screen includes a hearing test using objective measures. Providers who do not have equipment to give an objective hearing test are to refer patients to the appropriate specialist for screening. Hearing tests are given by the Department of Education in grades 1, 4, 7, and 10. Several schools also test kindergarten children. These screening efforts should not be duplicated unless the child is "at risk" and the situation warrants rescreening. Using an audiometer for testing children younger than four (4) years of age is left to the individual practice.
4.	Developmental assessment is to be accomplished by doing a health history assessment and an appropriate physical examination. Specific objective development testing is to be conducted and billed separately when an abnormality is suspected.
5.	Children is high-risk populations should be tested for tuberculosis in the first year.
6.	One (1) hematocrit or hemoglobin test is required during each time period (once during infancy, once during early childhood, once during late childhood, and once during adolescence). Performance of additional tests is left to the individual practice experience.
7.	Urinalysis is required at five (5) years of age and at least once during adolescence. The American Academy of Pediatrics recommends a urinalysis during each time period. Performance of additional tests is left to the individual practice experience. Bring up to date if not done at five (5) years of age.
8.	Appropriate preventive health counseling should be an integral part of each visit.

(Continued)

Table 23.1 – Footnote Codes

Code	Definition
Supplement To The AAP Periodicity Schedule	
(A)	The 4th dose of DTP should be given 6 to 12 months after the 3rd dose of DTP and may be given as early as 12 months of age, provided that the interval between doses 3 and 4 is at least 6 months and DTP is given. DTP should not be given at or after the 7th birthday. **DTAP is not currently licensed for use in children younger than 15 months. DTAP should not be given at or after the 7th birthday.**
(B)	MMR should be given at 12 months of age in high-risk areas. Tuberculin testing may be done at the same visit.
(C)	Infants of mothers who tested seropositive for Hepatitis (HbsAg+) must also receive Hepatitis B Immune Globulin (HBIG) at or shortly after the first dose, a second hepatitis B vaccine dose at 1 month, and a third hepatitis B vaccine injection at 6 months of age. Physicians may decide that infants of mothers who tested seronegative begin the three-dose schedule after the baby has left the hospital.
(D)	Check with individual manufacturer's instructions for administration of Haemophilus Influenza Type B (HIB) recommendations. Combination DTP/HIB may be used when both shots are scheduled simultaneously.
(E)	(Optional) All children under five (5) years of age, pregnant women, postpartum women up to six (6) months, and postpartum women who are breast-feeding up to one (1) year, may be referred to WIC. To locate the nearest site for this nutrition program, those referred should call the Family Wellness Helpline at 1-800-433-0746.
(F)	Blood lead screening should initially be done in infancy between six (6) to eight (8) months. Subsequent testing may be done annually up to six (6) years of age. High risk groups should be tested at every visit through six (6) years of age. Bring up to date if not done at six (6) to eight (8) months.
(G)	Providers are responsible for referring children for dental services beginning at eighteen (18) months of age unless a problem starts earlier. The Indiana Dental Association recommends check ups every six (6) months.
(H)	Providers are responsible for referring children for vision services beginning at three (3) years of age.

(Continued)

Table 23.1 – Footnote Codes

Code	Definition
Accelerated Periodicity Schedule	
(a)	Interruption of the recommended schedule with a delay between doses does not interfere with the final immunity achieved, nor does it necessitate starting the series over again, regardless of the length of time elapsed.
(b)	If the third dose of polio vaccine was received before the fourth birthday, a fourth dose may be given at school entry. Fourth dose is not needed if the third dose was given after fourth birthday.
(c)	Two doses of MMR vaccine are now recommended. Two doses of Measles (MMR preferred) should be administered by age 11-12. The second dose of MMR may be administered thirty (30) days after the first dose. MMR vaccines should not be given to pregnant females. For post-pubertal females in need of measles, mumps, or rubella vaccines, reasonable precautions should be used: 1) Asking her if she is pregnant, 2) Excluding those who say they are, and 3) Explaining the theoretical risks of the vaccine to the others and counseling them not to become pregnant for three months after the vaccination. It is not recommended that females sign a separate waiver other than the appropriate Important Information Statement or Vaccine Information Pamphlet. Vaccine containing rubella is highly indicated for children who may be in contact with susceptible pregnant women – the shed virus is not communicable. MMR-2 is especially recommended for all new entering college students and may be administered at any time thirty days after the first dose.
(d)	If the first dose of HIB was given after 15 months of age, no additional doses are recommended. For healthy children, do not administer after age five (59 months of age). Refer to ACIP recommendations.
(e)	If the fourth dose of DTP was administered after the fourth birthday, there is no need to administer the fifth dose.

Exit – Click once to exit the Periodicity and Screening Key Window and return to the previous window.

The scrolling bar located on the left of the screen allows the user to scroll up and down through the document.

Section 24: Member EPSDT Notices Window

Introduction

The Member EPSDT Notices window is used by IFSSA to display the history of notices sent to EPSDT eligible members. The Member EPSDT Notices window is accessed through the Member Base window by clicking **EPSDT** and **RECIP NOTICES**, or by pressing **Alt+O**, **Shift+E**, **Shift+N**.

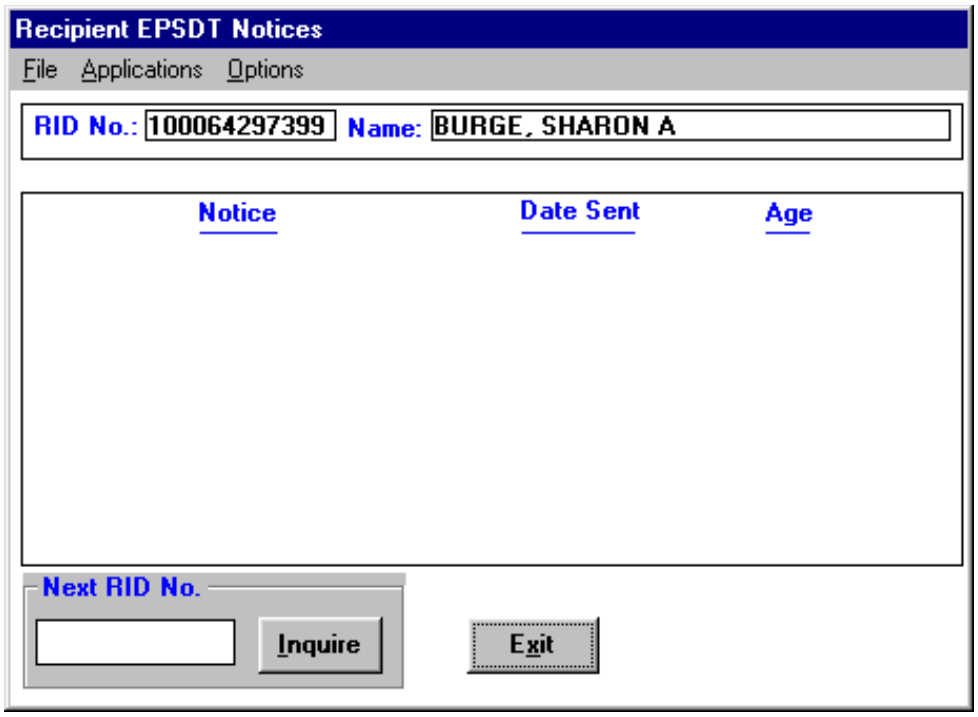

Figure 24.1 – Member EPSDT Notices Window

File	Applications	Options	
Print	Adhoc Reporting	Base	
Exit	Claims	CSHCS	
Exit Indiana*AIM*	Financial	Eligibility-	Standard
	Managed Care		Replaced
	MARS	EOMB Request	
	Prior Authorization	EPSDT-	Abnormalities w/modifiers
	Provider		Abnormalities w/out modifiers
	Member		Missed appointment schedules
	Reference		Periodicity Schedules-
	Security		Accelerated Schd 2 to 6
	SURS		Accelerated Schd 7 to 17
	Third Party Liability		Accelerated Schd 18 and over
	System Parms		Regular Screening
	Research/Project Tracking System		Regular Supplement
			Recip abnormalities
			Recip notices
			Recip screenings
		ID Cards	
		Lock-in-	Lockin Base
			Lock Notification
			Lock Prov Notification
			Lock Prov End Notification
			Lock Utilization
		LOC	
		Medicare-	Billing A Mismatches
			Billing B Mismatches
			Buyin Coverage
			Dual Aid Eligibility
			Medicare Coverage
			Override
			Part A Billing
			Part B Billing
			Premium 150
			Premium S15
			Premium S15 Exceptions
			Premium 150 Exceptions
		Patient Liab	
		Potential MC Recip	
		Previous-	Addresses
			Names
			PCNs
		PMP Assignment	
		Recip Mother RID	
		Redetermination Date	
		Search	
		Spenddown	
		590 Search	
		Suspended ICES Dupe	
		Link History	
		Mgd Care Rate Cell	
		Newborn PMP History	

Figure 24.2 - Member EPSDT Notices Window Menu Tree

Figure 24.2 is an illustration of a menu tree for the Member EPSDT Notices Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member EPSDT Notices Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member EPSDT Notices window, and exit Indiana*AIM*.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Exit IndianaAIM – Exits the user from Indiana*AIM*

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility, dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with modifiers

- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Field Information

Field Name: *RID No.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's name

Format – 29 alphabetic characters with special character options (space, hyphen, and apostrophe)

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name: *NOTICE*

Description – EPSDT notices sent to eligible members

Format – 30 alphabetic characters

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name: *DATE SENT*

Description – Date EPSDT notices were sent to the member

Format – CCYYMMDD

Features – Protected. Display only.

Edits – None

To Correct – N/a

Field Name: *AGE*

Description – Age of the EPSDT member when notice was sent

Format – 11 alphabetic characters

Features – Protected. Display only.

Edits – None

To Correct – N/a

System Information

PBL – RECIP04.PBL

Window – W_RE_EPSDT_RECIP_NOTICES

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_EPSDT_RECIP_NOTICES

System Features

Click **EXIT** to exit from the Member EPSDT Notices window and return to the previous window.

Section 25: Member ID Cards Window

Introduction

IFSSA and EDS use the Member ID Card window to view and verify all ID card issuance for a member. This window allows the user to view all the ID cards that were issued as well as the reason the card was issued. This allows the user to spot potential problems if too many ID cards were issued to a member. The ID Card window will be accessed through the Member Base window by clicking **ID CARD**, or by pressing **Alt+O**, **Shift+I**.

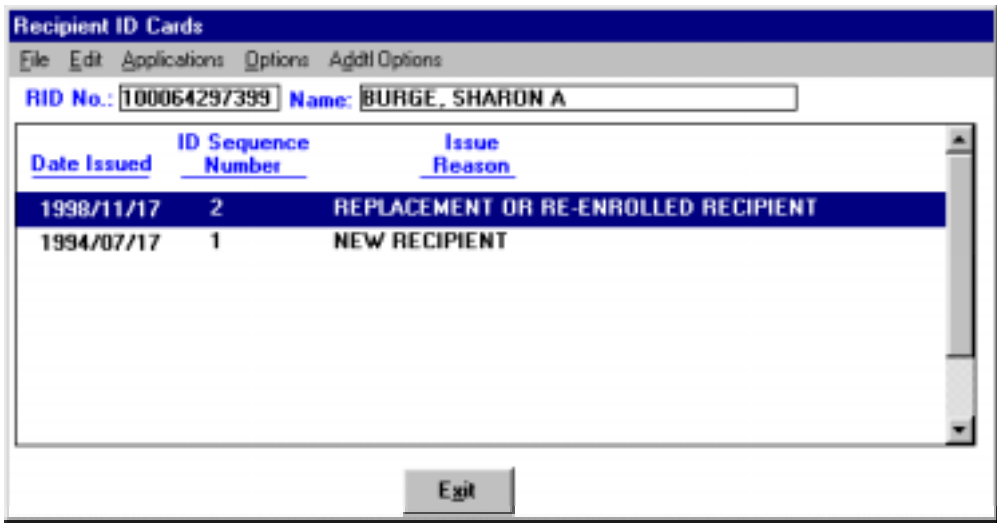

Figure 25.1 – Member ID Cards Window

File	Edit	Applications	Options		Addt'l Options
Delete	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Print	Paste	Claims	CSHCS		TPL Search/Resource
Exit	Cut	Financial	Eligibility-	Standard	
Audit		Managed Care		Replaced	
Exit Indiana*AIM*		MARS	EOMB Request		
		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 25.2 - Member ID Cards Window Menu Tree

Figure 25.2 is an illustration of a menu tree for the Member ID Cards Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member ID Cards Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member ID Cards window, and exit Indiana*AIM*.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected-display only

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's name

Format – 29 alphabetic characters with special character options (space, hyphen, and apostrophe)

Features – Protected-display only

Edits – None

To Correct – N/a

Field Name: *DATE ISSUED*

Description – Displays the date that the ID card extract record was transmitted to EDS Operations for the ID card to be issued

Format – Eight character numeric (CCYY/MM/DD)

Features – None

Edits – None

To Correct – N/a

Field Name: *ID SEQUENCE NUMBER*

Description – Displays the sequence number of the card issued for this member. The most current card is shown on the first row of the list of ID cards.

Format – Two numeric characters

Features – None

Edits – None

To Correct – N/a

Field Name: *ISSUE REASON*

Description – Displays the reason the ID card was issued. The issue reason codes are converted to their actual description for readability.

Format – 42 alphabetic characters. Valid values are the following:

- New member card
- Replacement or re-enroll
- Lost card
- Damaged card
- Stolen card
- Changed information (Name, DOB, Sex)

Features – None

Edits – None

To Correct – N/a

System Information

PBL – RECIP04.PBL

Window – W_RE_ID_CARD

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_ID_CARD

Section 26: CSHCS Provider Eligibility Window

Introduction

IFSSA and EDS use the CSHCS Provider Eligibility window to view and verify the providers eligible for a specific CSHCS member. The CSHCS Provider Eligibility window accessed through the Member Base window by clicking **CSHCS**, or by pressing **Alt+O**, **Shift+H**.

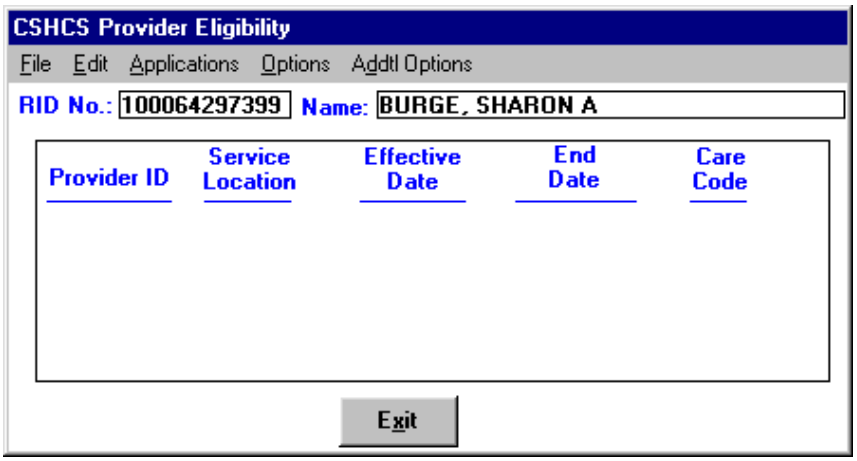

Figure 26.1 – CSHCS Provider Eligibility Window

File	Edit	Applications	Options		Addt'l Options
Delete	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Print	Paste	Claims	CSHCS		TPL Search/Resource
Exit	Cut	Financial	Eligibility-	Standard	
Audit		Managed Care		Replaced	
Exit Indiana*AIM*		MARS	EOMB Request		
		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security			Accelerated Schd 2 to 6
		SURS			Accelerated Schd 7 to 17
		Third Party Liability			Accelerated Schd 18 and over
		System Parms			Regular Screening
		Research/Project Tracking System			Regular Supplement
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 26.2 - CSHCS Provider Eligibility Window Menu Tree

Figure 26.2 is an illustration of a menu tree for the CSHCS Provider Eligibility Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the CSHCS Provider Eligibility Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu selections File, Edit, Applications, and Menu Selection: File

This command allows the user to print the window, exit the CSHCS Provider Eligibility window, and exit Indiana*AIM*.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*.

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Pastes text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches

- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID No.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected-display only

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's name

Format – 29 alphabetic characters with special character options (space, hyphen, and apostrophe)

Features – Protected-display only

Edits – None

To Correct – N/a

Field Name: *PROVIDER ID*

Description – Provider's identification number

Format – Nine alphanumeric characters

Features – Protected-display only

Edits – None

To Correct – N/a

Field Name: *EFFECTIVE DATE*

Description – Effective date that is assigned to a provider for a specific member

Format – CCYYMMDD

Features – Protected-display only

Edits – None

To Correct – N/a

Field Name: *END DATE*

Description – End date that is assigned to a provider for a specific member

Format – CCYYMMDD

Features – Protected-display only

Edits – None

To Correct – N/A

Field Name: *CARE CODE*

Description – The code to indicate the type of care that the provider renders to the CSHCS member. Valid values include the following:

- *P* – Primary care physician
- *S* – Specialty
- *H* – Approved hospital
- *D* – Dentist

Format – One alphabetic character

Features – Protected-display only

Edits – None

To Correct – N/a

System Information

PBL – RECIP04.PBL

Window – W_RE_CSHCS_PROV

Data Windows – DW_RE_CSHCS_PROV

Menu – M_RE_MAINTENANCE

System Features

Click **EXIT** to exit the window.

Section 27: Member EOMB Request Window

Introduction

IFSSA and EDS use the Member EOMB Request window to enter requests for member EOMBs by provider and/or health program. The Member EOMB Request window is accessed through the Member Base window by clicking **EOMB REQUEST**, or by pressing **Alt+O**, **Shift+O**.

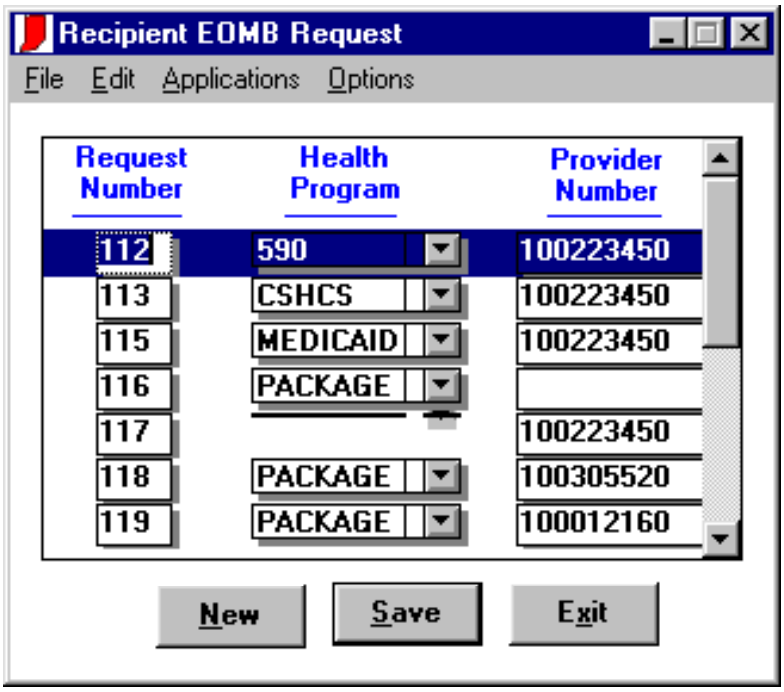

Figure 27.1 – Member EOMB Request Window

File	Edit	Applications	Options	
New	Copy	Adhoc Reporting	Base	
Save	Paste	Claims	CSHCS	
Print	Cut	Financial	Eligibility	Standard
Exit		Managed Care		Replaced
Audit		MARS	EOMB Request	
Exit Indiana*AIM*		Prior Authorization	EPSDT-	Abnormalities w/modifiers
		Provider		Abnormalities w/out modifiers
		Member		Missed appointment schedules
		Reference		Periodicity Schedules-
		Security		Accelerated Schd 2 to 6
		SURS		Accelerated Schd 7 to 17
		Third Party Liability		Accelerated Schd 18 and over
		System Parms		Regular Screening
		Research/Project Tracking System		Regular Supplement
				Regular Supplement
				Recip abnormalities
				Recip notices
				Recip screenings
			ID Cards	
			Lock-in-	Lockin Base
				Lock Notification
				Lock Prov Notification
				Lock Prov End Notification
				Lock Utilization
			LOC	
			Medicare-	Billing A Mismatches
				Billing B Mismatches
				Buyin Coverage
				Dual Aid Eligibility
				Medicare Coverage
				Override
				Part A Billing
				Part B Billing
				Premium 150
				Premium S15
				Premium S15 Exceptions
				Premium 150 Exceptions
			Patient Liab	
			Potential MC Recip	
			Previous-	Addresses
				Names
				PCNs
			PMP Assignment	
			Recip Mother RID	
			Redetermination Date	
			Search	
			Spenddown	
			590 Search	
			Suspended ICES Dupe	
			Link History	
			Mgd Care Rate Cell	
			Newborn PMP History	

Figure 27.2 - Member EOMB Request Window Menu Tree

Figure 27.2 is an illustration of a menu tree for the Member EOMB Request Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member EOMB Request Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member EOMB Request window, and exit Indiana*AIM*.

New – Allows the user to add a new segment.

Save – Saves entered information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*.

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user Care to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Field information

Field Name: *REQUEST NUMBER*

Description – Requestors identification number

Format – Three alphanumeric characters

Features – None

Edits – 91006 - Request Number Field is required!

To Correct – Enter a request number

Field Name: *HEALTH PROGRAM*

Description – Requested Health Program

Format – Drop down list box. Valid values are the following:

- *MA* – Medicaid
- *59* – 590
- *K2* – Hoosier Healthwise Package C
- *AR* – ARCH

Features – Pop-up window

- Double-click to see the pop-up window
- Select form pop-up window, if desired

Edits – 91006 - Provider number and/or program code field is required

To Correct – Enter a program code and/or a provider number

Field Name: ***PROVIDER NUMBER***

Description – Requested billing Provider Number.

Format – Nine alphanumeric characters

Features – None

Edits – 5052 - Provider ID not found!

To Correct – Verify entry. Enter valid provider ID.

5093 - Provider ID must be nine characters!

To Correct – Verify entry. Enter nine-character provider ID.

System Information

PBL – RECIP02.PBL

Window – W_RE_EOMB_REQUEST2

Data Windows – DW_RE_EOMB_REQ

Menu – M_RE_MAINTENANCE

System Features

The **New** button on the Member EOMB Request window allows the user to add a new EOMB request. The **Save** button allows the user to save changes made to the window and the **Exit** button allows the user to exit the window.

Section 28: Potential Managed Care Member Window

Introduction

The Potential Managed Care Member window allows the user to inquire about members who were identified by Indiana*AIM*, based on the ICES update, as mandatory Hoosier Healthwise enrollees. The window also displays current status and indicates if the member will be auto-assigned. The Potential Managed Care Member window is accessed through the Member Base window by clicking **POTENTIAL MC RECIP**, or by pressing **Alt+T**.

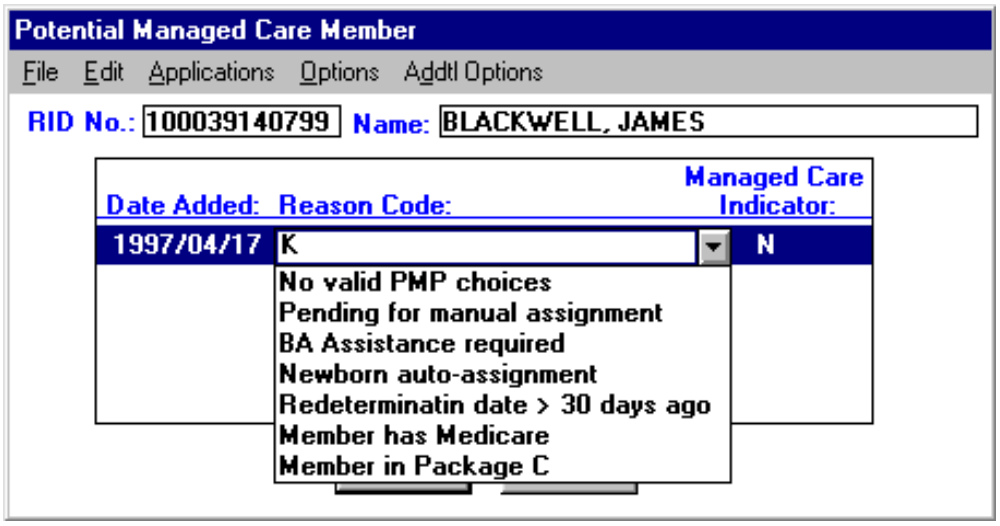

Figure 28.1 – Potential Managed Care Member Window

File	Edit	Applications	Options		Addt'l Options
Delete	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Print	Paste	Claims	CSHCS		TPL Search/Resource
Exit	Cut	Financial	Eligibility-	Standard	
Audit		Managed Care		Replaced	
Exit Indiana*AIM*		MARS	EOMB Request		
		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security			Accelerated Schd 2 to 6
		SURS			Accelerated Schd 7 to 17
		Third Party Liability			Accelerated Schd 18 and over
		System Parms			Regular Screening
		Research/Project Tracking System			Regular Supplement
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buy-in Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 28.2 - Potential Managed Care Member Window Menu Tree

Figure 28.2 is an illustration of a menu tree for the Potential Managed Care Member Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Potential Managed Care Member Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Potential Managed Care Member window, and exit Indiana*AIM*.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Pastes text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches

- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- Pcns
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 character numeric

Features – Protected - Display only

Edits – None

To Correct – N/A

Field Name: *NAME*

Description – Member's name

Format – 29 character alphabetic with special character options (space, hyphen, and apostrophe)

Features – Protected - Display only

Edits – None

To Correct – N/A

Field Name: *DATE ADDED*

Description – Date the member was identified as a potential Hoosier Healthwise enrollee or changed to his or her current status

Format – CCYY/MM/DD

Features – Protected - Display only

Edits – None

To Correct – N/A

Field Name: *REASON CODE*

Description – Reason the member was added as a potential Hoosier Healthwise member or the member's current status

Format – alphabetic

Features – Drop-down list box. Valid values include the following:

- No valid PMP choices
- Pending for manual assignment
- BA Assistance required
- Newborn auto-assignment
- Redetermination date > 30 days ago
- Member has Medicare
- PCCM Voluntary DSNRL
- RBMC Voluntary DSNRL
- PCCM Mandatory DSNRL
- RBMC Mandatory DSNRL
- Disabled
- RBMC DSNRL – Joins PCCM
- RBMC DSNRL – Fee for Svc
- RBMC DSNRL – PMP NoResponse
- CHIPS
- Package C

Edits – 4142 Code is auto-assigned and cannot be changed!

To Correct – Verify entry. User can not change an auto-assigned code.

4143 - Cannot change to auto-assigned Code!

To Correct – Verify entry. User can not select an auto-assigned code.

Field Name: *MANAGED CARE INDICATOR*

Description – Indicates if the member will be auto-assigned into the Hoosier Healthwise program

Format – One character alphabetic

Features – Protected - Display only

Edits – None

To Correct – N/A

System Features

The **Save** button on the Potential Managed Care Members window allows the user to save changes made to the window. The **Exit** button allows the user to exit the Potential Managed Care Members window and return to the previous window.

System Information

PBL – RECIP01.PBL

Window – W_RE_MC_RECIP

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_MC_RECIP

DW_RE_HEADER

Section 29: Member Redetermination Date Window

Introduction

The Member Redetermination Date window allows the user to inquire on the last date the member was redetermined for IHCP benefits. It also displays the next date the member is scheduled for benefit redetermination. The member has 30 days from the date of redetermination to make a PMP selection. If the member does not make a selection, Indiana*AIM* automatically assigns a PMP. The Member Redetermination Date window will be accessed through the Member Base window by clicking on the **REDETERMINATION DATE**, or by pressing **Alt+O**, and **Alt+D**.

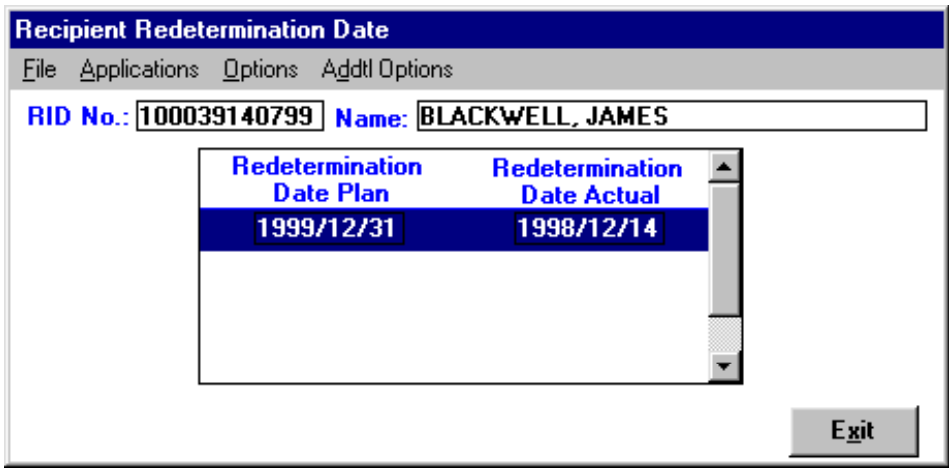

Figure 29.1 – Member Redetermination Date Window

File	Applications	Options		Addt'l Options
Print	Adhoc Reporting	Base		SUR EOMB Rqst
Exit	Claims			TPL Search/Resource
Audit	Financial	Eligibility-	Standard	
Exit Indiana*AIM*	Managed Care		Replaced	
	MARS	EOMB Request		
	Prior Authorization	EPSDT-	Abnormalities w/modifiers	
	Provider		Abnormalities w/out modifiers	
	Member		Missed appointment schedules	
	Reference		Periodicity Schedules-	
	Security		Accelerated Schd 2 to 6	
	SURS		Accelerated Schd 7 to 17	
	Third Party Liability		Accelerated Schd 18 and over	
	System Parms		Regular Screening	
	Research/Project Tracking System		Regular Supplement	
			Recip abnormalities	
			Recip notices	
			Recip screenings	
		ID Cards		
		Lock-in-	Lockin Base	
			Lock Notification	
			Lock Prov Notification	
			Lock Prov End Notification	
			Lock Utilization	
		LOC		
		Medicare-	Billing A Mismatches	
			Billing B Mismatches	
			Buyin Coverage	
			Dual Aid Eligibility	
			Medicare Coverage	
			Override	
			Part A Billing	
			Part B Billing	
			Premium 150	
			Premium S15	
			Premium S15 Exceptions	
			Premium 150 Exceptions	
		Patient Liab		
		Potential MC Recip		
		Previous-	Addresses	
			Names	
			PCNs	
		PMP Assignment		
		Recip Mother RID		
		Redetermination Date		
		Search		
		Spenddown		
		590 Search		
		Suspended ICES Dupe		
		Link History		
		Mgd Care Rate Cell		
		Newborn PMP History		

Figure 29.2 - Member Redetermination Date Window Menu Tree

Figure 29.2 is an illustration of a menu tree for the Member Redetermination Date Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Redetermination Date Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press ALT.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member Redetermination Date window, and exit Indiana*AIM*.

Print – Allows the user to print the screen, top window or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

Exit IndianaAIM – Exits the user from Indiana*AIM*

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates, and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop down - list box forEPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare" The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions

- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- Pcns
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 character numeric

Features – Protected - Display only

Edits – None

To Correct – N/A

Field Name: *NAME*

Description – Member's name

Format – 29 character alphabetic with special character options (space, hyphen, and apostrophe)

Features – Protected - Display only

Edits – None

To Correct – N/A

Field Name: *REDETERMINATION DATE PLAN*

Description – Date the member is scheduled for redetermination of benefits.

Format – CCYY/MM/DD

Features – Protected - Display only

Edits – None

To Correct – N/A

Field Name: *REDETERMINATION DATE ACTUAL*

Description – Last date the member was redetermined for benefits. If the member is a mandatory Hoosier Healthwise member, he or she must select a PMP within 30 calendar days of this date. A member may also change a PMP within 30 calendar days of this date.

Format – CCYY/MM/DD

Features – Protected - Display only

Edits – None

To Correct – N/A

System Features

The **Exit** button allows the user to exit the Member Redetermination Date window and return to the previous window.

System Information

PBL – RECIP01.PBL

Window – W_RE_REDETERM_DTE

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_HEADER

DW_RE_REDETERM_DTE

Section 30: Member Mother RID Window

Introduction

The Member Mother RID window allows the user to inquire about the member identification number assigned by ICES to the mother of the displayed member. The RID of the mother is used to determine if a newborn should be auto-assigned to an MCO. The Member Mother RID window will be accessed through the Member Base window by clicking on the **MEMBER MOTHER RID**, or by pressing **Alt+O**, and **Alt+N**.

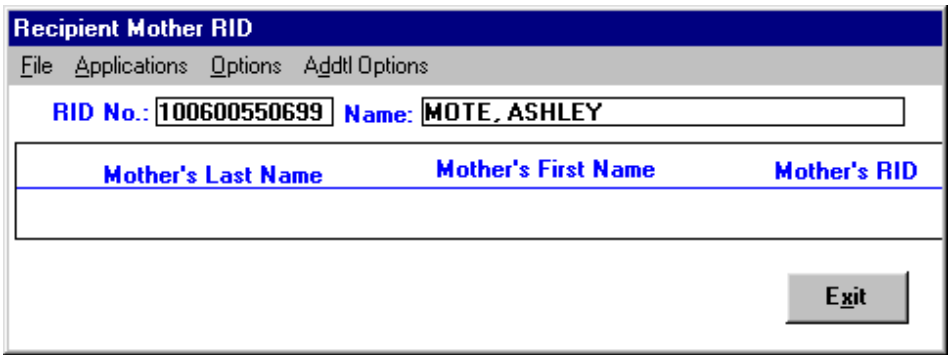

Figure 30.1 – Member Mother RID Window

File	Applications	Options		Addt'l Options
Print	Adhoc Reporting	Base		SUR EOMB Rqst
Exit	Claims	CSHCS		TPL Search/Resource
Audit	Financial	Eligibility-	Standard	
Exit Indiana*AIM*	Managed Care		Replaced	
	MARS	EOMB Request		
	Prior Authorization	EPSDT-	Abnormalities w/modifiers	
	Provider		Abnormalities w/out modifiers	
	Member		Missed appointment schedules	
	Reference		Periodicity Schedules-	
	Security			Accelerated Schd 2 to 6
	SURS			Accelerated Schd 7 to 17
	Third Party Liability			Accelerated Schd 18 and over
	System Parms			Regular Screening
	Research/Project Tracking System			Regular Supplement
			Recip abnormalities	
			Recip notices	
			Recip screenings	
		ID Cards		
		Lock-in-	Lockin Base	
			Lock Notification	
			Lock Prov Notification	
			Lock Prov End Notification	
			Lock Utilization	
		LOC		
		Medicare-	Billing A Mismatches	
			Billing B Mismatches	
			Buyin Coverage	
			Dual Aid Eligibility	
			Medicare Coverage	
			Override	
			Part A Billing	
			Part B Billing	
			Premium 150	
			Premium S15	
			Premium S15 Exceptions	
			Premium 150 Exceptions	
		Patient Liab		
		Potential MC Recip		
		Previous-	Addresses	
			Names	
			PCNs	
		PMP Assignment		
		Recip Mother RID		
		Redetermination Date		
		Search		
		Spenddown		
		590 Search		
		Suspended ICES Dupe		
		Link History		
		Mgd Care Rate Cell		
		Newborn PMP History		

Figure 30.2 - Member Mother RID Widow Menu Tree

Figure 30.2 is an illustration of a menu tree for the Member Mother RID Widow. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Mother RID Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member Mother RID window, and exit Indiana*AIM*.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected - Display only

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's name

Format – 29 alphabetic characters with special character options (space, hyphen, and apostrophe)

Features – Protected - Display only

Edits – None

To Correct – N/a

Field Name: *MOTHER'S LAST NAME*

Description – Mother's last name

Format – 15 alphanumeric characters

Features – Protected - Display only

Edits – None

To Correct – N/A

Field Name: *MOTHER'S FIRST NAME*

Description – Mother's first name

Format – 13 alphanumeric characters

Features – Protected - Display only

Edits – None

To Correct – N/a

Field Name: *MOTHER'S RID*

Description – Mother's member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected - Display only

Edits – None

To Correct – N/a

System Features

The **Exit** button allows the user to exit the Member Mother RID Window and return to the previous window

System Information

PBL – RECIP01.PBL

Window – W_RE_MOTHER_RID

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_HEADER

DW_RE_MOTHER_RID

Section 31: PMP Assignment History Window

Introduction

The PMP Assignment History window allows the user to inquire about the member's current and previous PMP assignments and their corresponding effective dates. The PMP Assignment History window is Member Base window by clicking **PMP ASSIGNMENT** or by pressing **Alt+O**, and **Alt+G**.

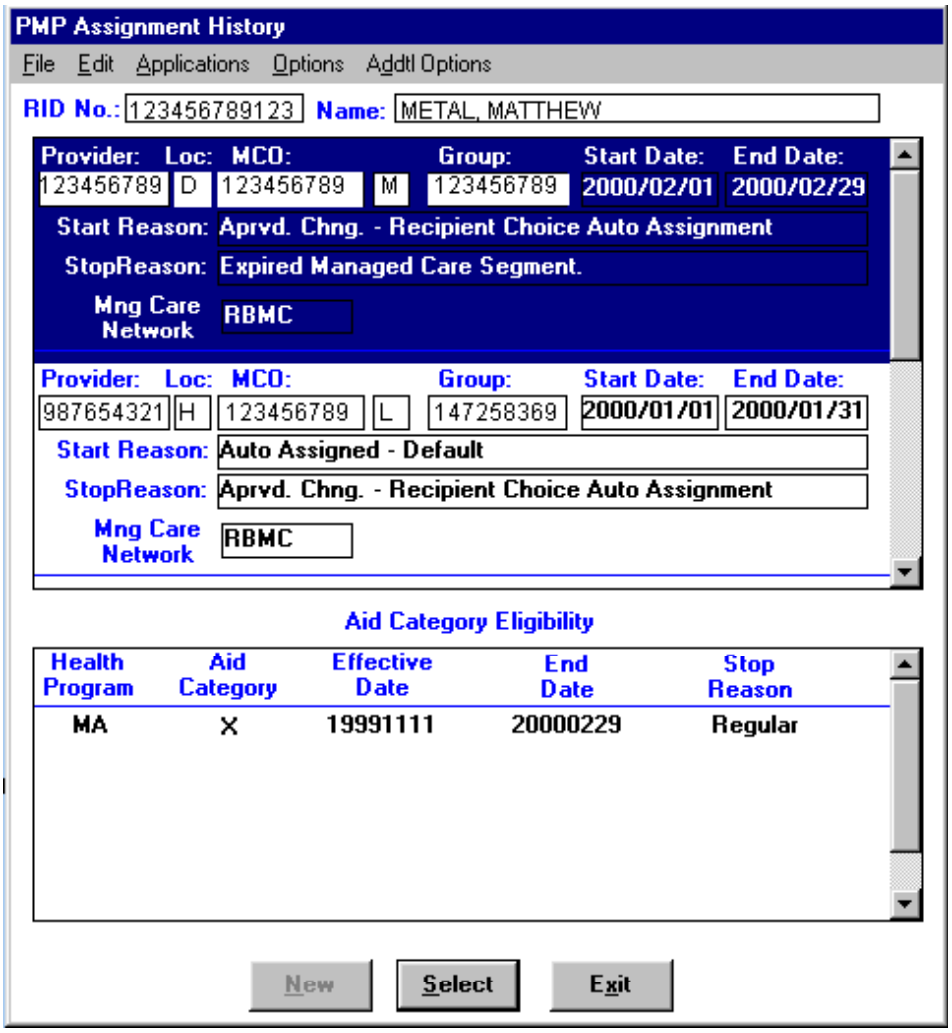

Figure 31.1 – PMP Assignment History Window

File	Edit	Applications	Options		Addt'l Options
New	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Delete	Paste	Claims	CSHCS		TPL Search/Resource
Print	Cut	Financial	Eligibility-	Standard	
Exit		Managed Care		Replaced	
Audit		MARS	EOMB Request		
Exit Indiana*AIM*		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 31.2 **-** PMP Assignment History Window Menu Tree

Figure 31.2 is an illustration of a menu tree for the PMP Assignment History Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the PMP Assignment History Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the PMP Assignment History window, and exit Indiana*AIM*.

New – Allows the user to add a new segment.

Delete – Click once to delete the highlighted text.

Print – Allows the user to print the window.

Exit – Returns the user to the previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Edit

This menu command allows the user to make adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Paste text that was cut or copied from another area within the reference functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

This menu options allows the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the CLAIMS history files.

Financial – Allows the user to access the Financial windows.

MARS – Allows the user to access MARS information

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

Third Party Liability – Allows the user to access the Third Party Liability windows.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the member base screen of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and

the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop down - list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop down - list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches
- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing

- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description – The member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected. Display only

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's name

Format – 29 alphabetic characters with special character options (space, hyphen, and apostrophe)

Features – Protected - Display only

Edits – None

To Correct – N/a

Field Name: *PROVIDER*

Description – IHCP provider number of the member's PMP for this date segment.

Format – Nine numeric characters

Features – Protected. Display only

Edits – None

To Correct – N/a

Field Name: *LOC*

Description – One character alphabetic identifier that indicates the service location of the PMP displayed, the member was assigned.

Format – One alphabetic character

Features – Protected. Display only

Edits – None

To Correct – N/a

Field Name: *PMP GROUP NUMBER*

Description – IHCP identification number of the group, if any, to which the provider is affiliated

Format – Nine alphanumeric characters

Features – Protected - Display only

Edits – None

To Correct – N/a

Field Name: *MCO NUMBER*

Description – IHCP identification number of the MCO, if any, to which the PMP is affiliated at the time of member assignment.

Format – Nine alphanumeric characters

Features – Protected. Display only

Edits – None

To Correct – N/a

Field Name: *START DATE*

Description – Date the member was assigned to the displayed PMP.

Format – CCYY/MM/DD

Features – Protected. Display only

Edits – None

To Correct – N/a

Field Name: *END DATE*

Description – Date the member ended his or her relationship with this PMP

Format – CCYY/MM/DD

Features – Protected. Display only

Edits – None

To Correct – N/a

Field Name: *START REASON*

Description – Reason the member began his or her relationship with this PMP

Format – 50 alphanumeric characters

Features – Valid Values include the following:

- New eligible
- Redetermination
- 6 month PMP change
- Newborn auto-assign change
- Member initiated - MCO disenrollment
- *Aprvd. Chng*. - Inconvenient Location
- *Aprvd. Chng*. - Member moved
- *Aprvd. Chng*. - Transportation problems
- *Aprvd. Chng*. - Appointment delays
- *Aprvd. Chng*. - Waiting time
- *Aprvd. Chng*. - Treatment by staff
- *Aprvd. Chng*. - Unsatisfactory explanation
- *Aprvd. Chng*. - Unsatisfactory quality of care
- *Aprvd. Chng*. - Unsatisfactory emergency response

- *Aprvd. Chng*. - Unable to obtain referral
- *Aprvd. Chng*. - Insufficient after-hours coverage
- *Aprvd. Chng*. - Physician no longer Medicaid
- *Aprvd. Chng*. - Physician no longer in practice
- *Aprvd. Chng*. - Relationship unacceptable
- *Aprvd. Chng*. - Medical condition not appropriate
- *Aprvd. Chng*. - Physician refused client
- *Aprvd. Chng*. - Specialty not consistent
- *Aprvd. C*hng. - Pregnancy - Antepartum change
- *Aprvd. Chng*. - Pregnancy - Postpartum change
- *Aprvd. Chng*. - Other
- *Auto assigned* - Newborn
- Auto assigned - Case Assignment
- *Auto assigned* - Previous PMP
- *Auto assigned* - Default
- Voluntary county enrollment

Edits – None

To Correct – N/a

Field Name: *STOP REASON*

Description – Reason the member terminated his or her relationship with this PMP

Format – 50 alphanumeric characters

Features – Protected - Display only. Valid values include the following:

- Redetermination
- Six month PMP change
- Newborn auto-assign change
- Member initiated - MCO disenrollment
- *Aprvd. Chng*. - Inconvenient Location
- *Aprvd. Chng*. - Member moved
- *Aprvd. Chng*. - Transportation problems

- *Aprvd. Chng*. - Appointment delays
- *Aprvd. Chng*. - Waiting time
- *Aprvd. Chng*. - Treatment by staff
- *Aprvd. Chng*. - Unsatisfactory explanation
- *Aprvd. Chng*. - Unsatisfactory quality of care
- *Aprvd. Chng*. - Unsatisfactory emergency response
- *Aprvd. Chng*. - Unable to obtain referral
- *Aprvd. Chng*. - Insufficient after-hours coverage
- *Aprvd. Chng*. - Physician no longer Medicaid
- *Aprvd. Chng*. - Physician no longer in practice
- *Aprvd. Chng*. - Relationship unacceptable
- *Aprvd. Chng*. - Medical condition not appropriate
- *Aprvd. Chng*. - Physician refused client
- *Aprvd. Chng*. - Specialty not consistent
- *Aprvd. Chng*. - Pregnancy - Antepartum change
- *Aprvd. Chng*. - Pregnancy - Postpartum change
- *Aprvd. Chng*. - Other
- Death
- Disenroll from Hoosier Healthwise
- *Auto assigned* - Newborn
- *Auto assigned* - Case Assignment
- *Auto assigned* - Previous PMP
- *Auto assigned* - Default

Edits – None

To Correct – N/a

System Features

The **New** button allows the user to add a new PMP segment. The **Select** button allows the user to access the PMP Assignment Maintenance window. The **Exit** button allows the user to exit the PMP Assignment History window and return to the previous window.

System Information

PBL – RECIP01.PBL

Window – W_RE_PMP_HIST

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_PMP_ASSIGN_SUMMARY

DW_RE_HEADER

Section 32: PMP Assignment Maintenance Window

Introduction

The PMP Assignment Maintenance window allows the user to add a new PMP segment for a member or update the existing PMP assignment segment. The PMP Assignment Maintenance window will be accessed through the PMP Assignment History window by clicking **New**, or by pressing **Alt+N**.

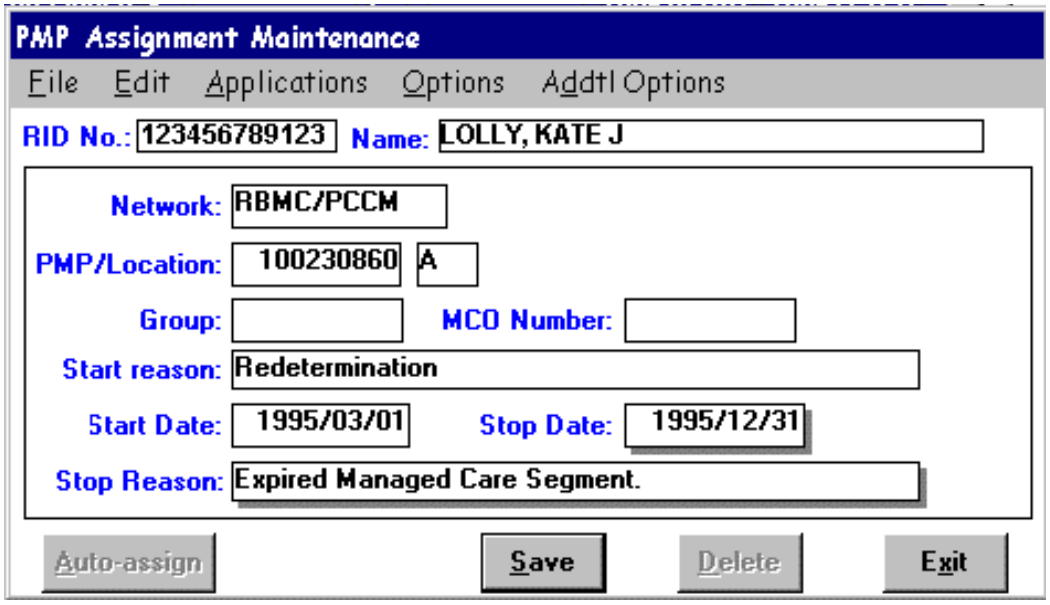

Figure 32.1 – PMP Assignment Maintenance Window

File	Edit	Applications	Options		Addt'l Options
Delete	Copy	Adhoc Reporting	Base		SUR EOMB Rqst
Print	Paste	Claims	CSHCS		TPL Search/Resource
Exit	Cut	Financial	Eligibility-	Standard	
Audit		Managed Care		Replaced	
Exit Indiana*AIM*		MARS	EOMB Request		
		Prior Authorization	EPSDT-	Abnormalities w/modifiers	
		Provider		Abnormalities w/out modifiers	
		Member		Missed appointment schedules	
		Reference		Periodicity Schedules-	
		Security		Accelerated Schd 2 to 6	
		SURS		Accelerated Schd 7 to 17	
		Third Party Liability		Accelerated Schd 18 and over	
		System Parms		Regular Screening	
		Research/Project Tracking System		Regular Supplement	
				Recip abnormalities	
				Recip notices	
				Recip screenings	
			ID Cards		
			Lock-in-	Lockin Base	
				Lock Notification	
				Lock Prov Notification	
				Lock Prov End Notification	
				Lock Utilization	
			LOC		
			Medicare-	Billing A Mismatches	
				Billing B Mismatches	
				Buyin Coverage	
				Dual Aid Eligibility	
				Medicare Coverage	
				Override	
				Part A Billing	
				Part B Billing	
				Premium 150	
				Premium S15	
				Premium S15 Exceptions	
				Premium 150 Exceptions	
			Patient Liab		
			Potential MC Recip		
			Previous-	Addresses	
				Names	
				PCNs	
			PMP Assignment		
			Recip Mother RID		
			Redetermination Date		
			Search		
			Spenddown		
			590 Search		
			Suspended ICES Dupe		
			Link History		
			Mgd Care Rate Cell		
			Newborn PMP History		

Figure 32.2 - PMP Assignment Maintenance Window Menu Tree

Figure 32.2 is an illustration of a menu tree for the PMP Assignment Maintenance Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the PMP Assignment Maintenance Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press **ALT**.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the PMP Assignment Maintenance window, and exit Indiana*AIM*.

Delete – Allows user to delete a piece of existing information.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Pastes text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Base – Allows the user to access the Member Base window of the requested member.

CSHCS – Allows the user to access the CSHCS Provider Eligibility window.

Eligibility – Allows the user to access standard and replaced eligibility. Standard eligibility contains eligibility programs, eligibility dates and the aid categories for a member. Replaced eligibility displays any retroactively replaced eligibility.

EOMB Request – Allows the user to access the EOMB Request window.

EPSDT – Displays a drop-down list box for EPSDT. The drop-down list box allows the user to select one of the following options:

- Abnormalities with Modifiers
- Abnormalities without Modifiers
- Missed Appointment Codes
- Periodicity Schedules
- Member Abnormalities
- Member Notices
- Member Screenings

ID Cards – Allows the user to access the ID Card window for a member.

Lockin – Displays a drop-down list box for Lockin. The drop-down list box allows the user to select one of the following options:

- Lockin Base
- Lock Notification
- Lock Prov Notification
- Lock Prov End Notification
- Lock Utilization

LOC – Allows the user to access the Level of Care window.

Medicare – Displays a drop-down list box for Medicare. The drop-down list box allows the user to select one of the following options:

- Billing A Mismatches
- Billing B Mismatches

- Buy-In Coverage
- Dual Aid Eligibility
- Medicare Coverage
- Override
- Part B Billing
- Part A Billing
- Premium 150
- Premium S15
- Premium 150 Exceptions
- Premium S15 Exceptions

Patient Liab – Allows the user to access the Patient Liability window.

Potential MC Recip – Allows the user to access the Potential MC Recip window.

Previous – Displays a drop-down list box for Previous. The drop-down list box allows the user to select one of the following options:

- Names
- PCNs
- Addresses

PMP Assignment – Allows the user to access the PMP Assignment window. By clicking **Select** on the PMP Assignment window, the user can access the PMP Assignment Maintenance window.

Member Mother RID – Allows the user to access the Member Mother RID window.

Redetermination Date – Allows the user to access the redetermination date.

Search – Allows the user to access the Search Screen window.

Spenddown – Allows the user to access the Spenddown window.

590 Search – Allows user to access the 590 Enrollment Selection window.

Suspended ICES Dupe – Allows user to access the Suspend ICES Member Duplicates window.

Link History – Allows user to access the Member Link History window.

Mgd. Care Rate Cell – Allows user to access the Member Managed Care Rate Cell Eligibility window.

Newborn PMP History – Allows user to access the Newborn PMP Assignment History window.

Menu Selection: Addt'l Options

This menu allows the user to access the SUR EOMB Request window based on the member, if applicable.

SUR EOMB Rqst – This window allows the user to view all On Request EOMBs for the member. This window is used mainly for provider auditing purposes.

TPL Search/Resource – This window allows the user to view or search for TPL resource segments.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – Protected. Display only

Edits – None

To Correct – N/a

Field Name: *NAME*

Description – Member's name

Format – 29 alphabetic characters with special character options (space, hyphen, and apostrophe)

Features – Protected. Display only

Edits – None

To Correct – N/a

Field Name: *NETWORK*

Description – What network member will be assigned to.

Features – Drop down list box. Valid values include:

- RBMC/PCCM
- MCPD

Field Name: *PMP*

Description – The member's selected PMP.

Format – Nine numeric characters

Features – None

Edits – 4100 No match found!

To Correct – Verify entry and rekey

4148 - Provider not in Managed Care

To Correct – Verify entry and enter a Managed Care Provider

Field Name: *SERVICE LOCATION*

Description – Service location the member is selecting for PMP assignment.

Format – One alphabetic character

Features – None

Edits – 4147 Invalid provider location

To Correct – Verify entry and rekey

Field Name: *PMP GROUP NUMBER*

Description – The IHCP identification number of the group, if any, to which the provider is affiliated

Format –Nine alphabetic characters

Features – None

Edits – 4155 Provider not in entered group

To Correct – Verify entry and rekey. Provider must be in entered group.

Field Name: *MCO NUMBER*

Description – The IHCP identification number of the MCO, if any, to which the PMP is affiliated at the time of member assignment.

Format – Nine alphabetic characters

Features – Protected - Display only.

Edits – None

To Correct – N/a

Field Name: *START REASON*

Description – Reason the member is beginning a relationship with this PMP

Format – None

Features – Drop down - list box. Valid values include the following:

- New eligible
- Redetermination
- Six6 month PMP change
- Newborn auto-assign change
- Member initiated - MCO disenrollment
- *Aprvd. Chng*. - Inconvenient Location
- *Aprvd. Chng*. - Member moved
- *Aprvd. Chng*. - Transportation problems
- *Aprvd. Chng*. - Appointment delays
- *Aprvd. Chng*. - Waiting time
- *Aprvd. Chng*. - Treatment by staff
- *Aprvd. Chng*. - Unsatisfactory explanation
- *Aprvd. Chng*. - Unsatisfactory quality of care
- *Aprvd. Chng*. - Unsatisfactory emergency response
- *Aprvd. Chng*. - Unable to obtain referral
- *Aprvd. Chng*. - Insufficient after-hours coverage

- *Aprvd. Chng*. - Physician no longer Medicaid
- *Aprvd. Chng*. - Physician no longer in practice
- *Aprvd. Chng*. - Relationship unacceptable
- *Aprvd. Chng*. - Medical condition not appropriate
- *Aprvd. Chng*. - Physician refused client
- *Aprvd. Chng*. - Specialty not consistent
- *Aprvd. Chng*. - Pregnancy - Antepartum change
- *Aprvd. Chng*. - Pregnancy - Postpartum change
- *Aprvd. Chng*. - Other
- *Auto assigned* - Newborn
- *Auto assigned* - Case Assignment
- *Auto assigned* - Previous PMP
- *Auto assigned* - Default
- Voluntary county enrollment

Edits – None

To Correct – N/a

Field Name: *START DATE*

Description – Date the member's relationship with this PMP is effective. For members enrolled between the 26th and 10th of a month, this is the 15th of the month. For members enrolled between the 11th and 25th of a month, this is the first of the month. For newborns auto-assigned to a MCO, this is the member's date of birth.

Format –CCYY/MM/DD

Features – Protected. Display only

Edits – None

To Correct – N/a

Field Name: *STOP DATE (NEW)*

Description – Date the member's relationship with this PMP terminated

Format –CCYY/MM/DD

Features – This window is accessed by clicking **New** on the PMP Assignment History window, and the stop date will be provided by the system

Edits – None

To Correct – N/a

Field Name: *STOP DATE (SELECT)*

Description – Date the member's relationship with this PMP terminated

Format –CCYY/MM/DD

Features – This window is accessed by clicking **Select** on the PMP Assignment History window, there are no added features.

Edits – 91001 - Invalid Date (CCYYMMDD)!

To Correct – Verify entry and enter date in CCYYMMDD format.

91002 - Date must be numeric!

To Correct – Verify entry and rekey valid numeric values.

91003 - Date is required!

To Correct – Enter date.

4159 - Stop date must be entered!

To Correct – Enter stop date.

Field Name: *STOP REASON (NEW)*

Description – Reason the member's relationship with this PMP is terminated

Format – 29 alphabetic characters

Features – When this window is accessed by clicking **New** on the PMP Assignment History window, the stop reason will default to **Open**.

Edits – None

To Correct – N/a

Field Name: *STOP REASON (SELECT)*

Description – Reason the member's relationship with this PMP is terminated

Features – This window is accessed by clicking **Select** on the PMP Assignment History window only the valid stop reasons. Valid values include the following:

- Redetermination
- Six month PMP change
- Newborn auto-assign change
- Member initiated - MCO disenrollment
- *Aprvd. Chng*. - Inconvenient Location
- *Aprvd. Chng*. - Member moved
- *Aprvd. Chng*. - Transportation problems
- *Aprvd. Chng*. - Appointment delays
- *Aprvd. Chng*. - Waiting time
- *Aprvd. Chng*. - Treatment by staff
- *Aprvd. Chng*. - Unsatisfactory explanation
- *Aprvd. Chng*. - Unsatisfactory quality of care
- *Aprvd. Chng*. - Unsatisfactory emergency response
- *Aprvd. Chng*. - Unable to obtain referral
- *Aprvd. Chng*. - Insufficient after-hours coverage
- *Aprvd. Chng*. - Physician no longer Medicaid
- *Aprvd. Chng*. - Physician no longer in practice
- *Aprvd. Chng*. - Relationship unacceptable
- *Aprvd. Chng*. - Medical condition not appropriate
- *Aprvd. Chng*. - Physician refused client
- *Aprvd. Chng*. - Specialty not consistent
- *Aprvd. Chng*. - Pregnancy - Antepartum change
- *Aprvd. Chng*. - Pregnancy - Postpartum change
- *Aprvd. Chng*. - Other
- Death
- Disenroll from Hoosier Healthwise

- Auto assigned - Newborn
- Auto assigned - Case Assignment
- Auto assigned - Previous PMP
- Auto assigned - Default

Edits – 4160 - Invalid Stop Reason - Recip Date of Death = 0

To Correct – Verify entry of death stop reason code. Member is not shown to be deceased on the base file.

Other Messages

Save Successful, Save Unsuccessful:

Edits – 8004. No changes keyed!

To Correct – No correction necessary. Information edit!

4027 - Provider is blank!

To Correct – Key provider number.

4145 - Member not eligible for Managed Care.

To Correct – No correction necessary. Member cannot be assigned to a PMP.

4147 - Invalid Provider Location.

To Correct – Verify entry. Provider location entered is not designated for PMP assignments.

4149 - Provider panel is full.

To Correct – No correction necessary. PMP cannot accept a new patient.

4150 - Recip in vol county, cannot assign to PCCM.

To Correct – No correction necessary. Member must select a MCO PMP.

4152 - Assignment not allowed. Age restriction.

To Correct – No correction necessary. PMP does not accept a member of this age.

4153 - Member and Provider specialty do not match.

To Correct – No correction necessary. PMP does not accept this type of member. For example, OB/GYN providers do not accept male members.

4154 - Member not in provider county.

To Correct – No correction necessary. Information edit.

4156 - Member is deceased.

To Correct – No correction necessary. Member is shown as deceased and cannot have a PMP segment.

4157 -Member aid cat not eligible for Managed Care.

To Correct – No correction necessary. Members aid category is not eligible for Hoosier Healthwise.

4161 - Service Location is required.

To Correct – Verify entry. Service location is required.

4162 - Start Reason is Required.

To Correct – Verify entry. A start reason must be selected.

4163 - Member not in provider region.

To Correct – Verify entry. The member must select a PMP in the MCO servicing their county.

System Features

The **Save** button allows the user to save changes made to the window. The **Exit** button allows the user to exit the PMP Assignment Maintenance window and return to the previous window. The **Delete** button allows the user to delete the displayed segment if a future start date is present. The **Auto-assign** button places the member in an auto-assigned status immediately. Members in an auto-assigned status are assigned by the system during the next auto-assignment cycle.

System Information

PBL – RECIP01.PBL

Window – W_RE_PMP_ASSIGN_MAINT

Menu – M_RE_MAINTENANCE

Data Windows – DW_RE_PMP_ASSIGN

DW_RE_HEADER

Section 33: Suspend ICES Member Duplicates Window

Introduction

The Suspend ICES Member Duplicates window allows the user to review all ICES records that have suspended due to a possible duplicate situation. The **Suspend ICES Member Duplicates** window will be accessed by clicking **SUSPENDED ICES DUPE** option, or by pressing **Alt+O** and **Alt+U**.

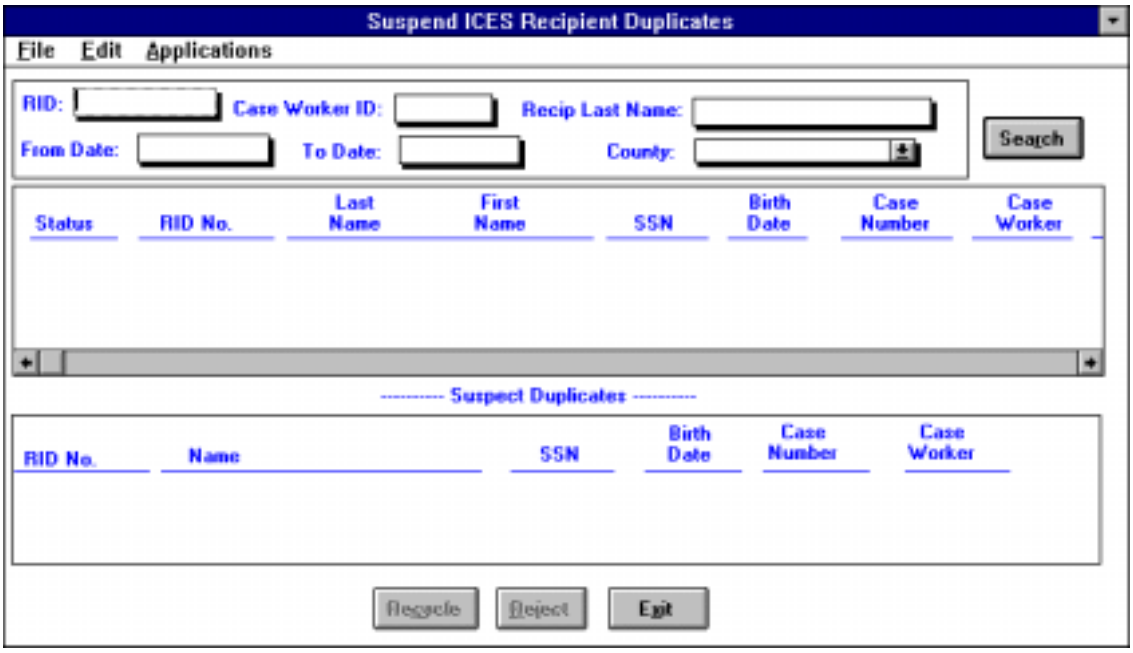

Figure 33.1 – Suspend ICES Member Duplicates Window

File	Edit	Applications
Print	Copy	Adhoc Reporting
Exit	Paste	Claims
Audit	Cut	Financial
Exit Indiana*AIM*		Managed Care
		MARS
		Prior Authorization
		Provider
		Member
		Reference
		Security
		SURS
		Third Party Liability

Figure 33.2 - Suspend ICES Member Duplicates Window Menu Tree

Figure 33.2 is an illustration of a menu tree for the Suspend ICES Member Duplicates Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Suspend ICES Member Duplicates Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press ALT.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Suspend ICES Member Duplicates window, and exit Indiana*AIM*.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

Audit – Allows the user to access the online audit trail windows.

*Exit Indiana*AIM – Exits the user from Indiana*AIM.*

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Pastes text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user Care to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user access the Research/Project Tracking System window.

Field Information

Field Name: *RID NO.*

Description – Member identification number assigned by ICES

Format – 12 numeric characters

Features – None

Edits – 4003-ID must be 12 characters!

To Correct – Verify entry. The RID No. must be 12 characters

91056 - Please enter at least one search field.

To Correct – An entry is required in order to search for a member. Key in the RID NO or choose an alternative search option

91007 - Data must be numeric!

To Correct – Enter a 12 character numeric value

91024 - No match found for RID No.!

To Correct – Enter a valid RID No. There was not a match on the member file for the ID keyed

Field Name: *CASE WORKER ID*

Description – Identifies the case worker that determined the member's eligibility

Format – Six alphanumeric characters

Features – Protected

Edits – 4010 Caseworker must be six characters.

Field Name: ***RECIP LAST NAME***

Description – Search by member's last name

Format – 15 alphanumeric characters

Features – None

Edits – 91024 No Match Found!

To Correct – Verify entry and rekey

Field Name: ***FROM DATE***

Description – ICES processing date from which to begin searching

Format – CCYYMMDD

Features – None

Edits – None

To Correct – N/a

Field Name: ***TO DATE***

Description – ICES processing date through which to search

Format – CCYYMMDD

Features – None

Edits – None

To Correct – N/a

Field Name: ***COUNTY***

Description– Member's county of residence

Format – Drop down list box. Valid values are displayed in Table 33.1.

Table 33.1 – Value Codes

Code	County Name	Code	County Name
01	ADAMS	36	JACKSON
02	ALLEN	37	JASPER
03	BARTHOLOMEW	38	JAY
04	BENTON	39	JEFFERSON
05	BLACKFORD	40	JENNINGS
06	BOONE	41	JOHNSON
07	BROWN	42	KNOX
08	CARROLL	43	KOSCIUSKO
09	CASS	44	LAGRANGE
10	CLARK	45	LAKE
11	CLAY	46	LAPORTE
12	CLINTON	47	LAWRENCE
13	CRAWFORD	48	MADISON
14	DAVIESS	49	MARION
15	DEARBORN	50	MARSHALL
16	DECATUR	51	MARTIN
17	DEKALB	52	MIAMI
18	DELAWARE	53	MONROE
19	DUBOIS	54	MONTGOMERY
20	ELKHART	55	MORGAN
21	FAYETTE	56	NEWTON
22	FLOYD	57	NOBLE
23	FOUNTAIN	58	OHIO
24	FRANKLIN	59	ORANGE
25	FULTON	60	OWEN
26	GIBSON	61	PARKE
27	GRANT	62	PERRY
28	GREENE	63	PIKE
29	HAMILTON	64	PORTER
30	HANCOCK	65	POSEY

(Continued)

Table 33.1 – Value Codes

Code	County Name	Code	County Name
31	HARRISON	66	PULASKI
32	HENDRICKS	67	PUTNAM
33	HENRY	68	RANDOLPH
34	HOWARD	69	RIPLEY
35	HUNTINGTON	70	RUSH
72	SCOTT	83	VERMILLION
73	SHELBY	84	VIGO
74	SPENCER	85	WABASH
75	STARKE	86	WARREN
76	STEUBEN	87	WARRICK
71	ST. JOSEPH	88	WASHINGTON
77	SULLIVAN	89	WAYNE
78	SWITZERLAND	90	WELLS
79	TIPPECANOE	91	WHITE
80	TIPTON	92	WHITLEY
81	UNION	94	IFSSA
82	VANDERBURGH	99	OUT OF STATE

Features – Protected

Edits – None

To Correct – N/a

Other Messages

None

System Features

The **Recycle** button located at the bottom of the Suspend ICES Member Duplicates window allows the user to recycle the selected members. The **Reject** button allows the user to reject the selected members. The **Exit** button allows the user to exit the Suspend ICES Member Duplicates window and return to the previous window.

System Information

PBL – RECIP03.PBL

Window – W_RE_ICES_DUPE

Menu – M_BASE_LIST_SEARCH_UPDATE

Data Windows – DW_RE_ICES_MATCH

DW_RE_ICES_PEND

DW_DR_ICES_SRCH

Section 34: Member Linking History Window

Introduction

The Member Linking History window allows the user to review all members who have had multiple RID numbers. The Member Linking History window will be accessed by pressing the **LINK HISTORY** option, or by entering **Alt+O** and **Alt+Y**.

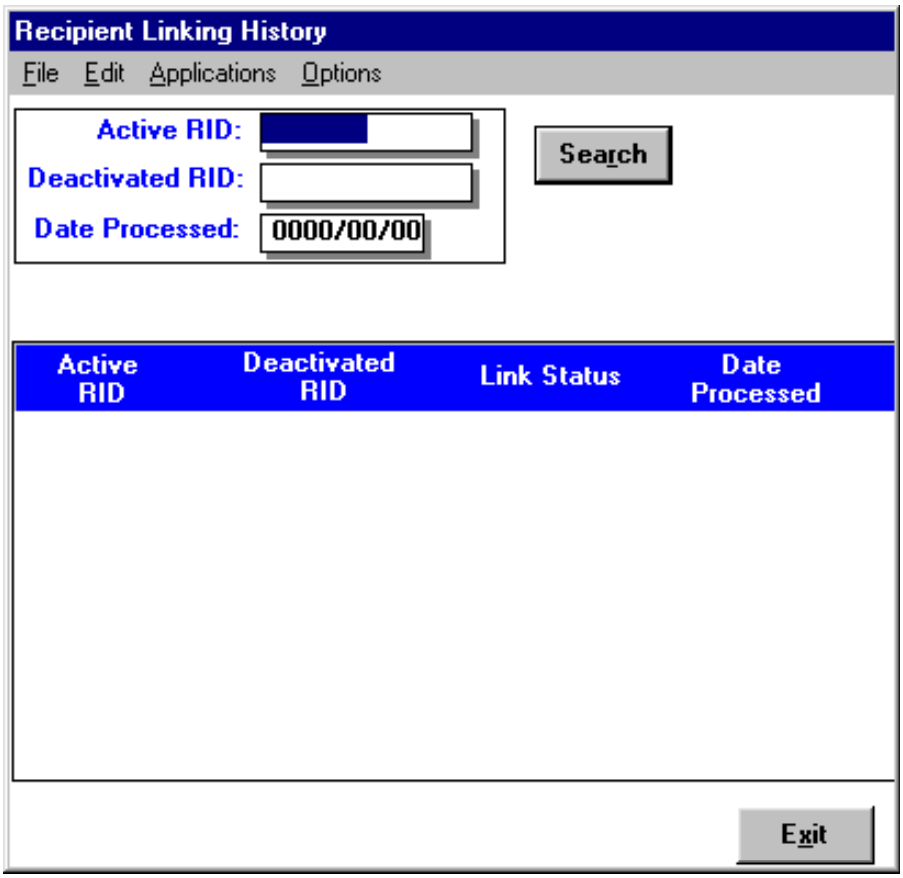

Figure 34.1 – Member Linking History Window

File	Edit	Applications	Options
Print	Copy	Adhoc Reporting	Search
Exit	Paste	Claims	
Exit Indiana*AIM*	Cut	Financial	
		Managed Care	
		MARS	
		Prior Authorization	
		Provider	
		Member	
		Reference	
		Security	
		SURS	
		Third Party Liability	
		System Parms	
		Research/Project Tracking System	

Figure 34.2 - Member Linking History Window Menu Tree

Figure 34.2 is an illustration of a menu tree for the Member Linking History Window. All menus appear in single-line boxes. The menu titles on this illustration reflect the overall menu commands and window options on the Member Linking History Window.

Menu Bar

The menu bar is located below the window's title bar and contains the heading for the list of commands or window options.

The list of available commands or window options appears in a drop-down list box. If a command or window option is faded, the command or window option is not available.

Select a command or window option in the following manner:

1. Click on the command or window option title.
2. Click on the desired option title and a drop-down box appears. Select the command. Double-click or select the underscored letter of each command and press ALT.

Menu selections File, Edit, Applications, and Options have the same functions as found on all the member windows.

Menu Selection: File

This command allows the user to print the window, exit the Member Linking History window, and exit Indiana*AIM*.

Print – Allows the user to print the screen, top window, or data window.

Exit – Returns the user to previous window.

*Exit Indiana*AIM – Exits the user from Indiana*AIM*.

Menu Selection: Edit

The commands or options under this menu selection allow adjustments to the data entered.

Copy – Copies text so the user can transfer the copied text to another area or application.

Paste – Pastes text that was cut or copied from another area within the chosen functional area.

Cut – Deletes the text and places it on the clipboard.

Menu Selection: Applications

The commands or options under this menu selection allow the user to access all the functional areas available in Indiana*AIM*.

Adhoc Reporting – Allows the user to access the Adhoc Reporting information.

Claims – Allows the user to access the Claims history files.

Financial – Allows the user to access the Financial windows.

Managed Care – Allows the user Care to access the Managed Care windows.

MARS – Allows the user to access MARS information.

Prior Authorization – Allows the user to access the Prior Authorization windows.

Provider – Allows the user to access the Provider windows.

Member – Allows the user to access the Member windows.

Reference – Allows the user to access the Reference windows.

Security – Allows the user to access the Security information.

SURS – Allows the user to access the SURS windows.

Third Party Liability – Allows the user to access the Third Party Liability windows.

System Parms – Allows the user to access the System Parms window.

Research/Project Tracking System – Allows the user to access the Research/Project Tracking System window.

Menu Selection: Options

This menu allows the user to access all the windows that relate to the member subsystem.

Search – Allows the user to access the Search Screen window

Field Information

Field Name: *ACTIVE RID*

Description – Member's current, active RID number

Format – 12 numeric characters

Features – None

Edits – 4003 - ID must be 12 characters!

To Correct – Verify entry. The RID No. must be 12 characters

91056 - Please enter at least one search field.

To Correct – An entry is required in order to search for a member. Key in the RID NO or choose an alternative search option

91007 - Data must be numeric!

To Correct – Enter a 12 character numeric value

91024 - No match found for RID No.!

To Correct – Enter a valid RID No. There was not a match on the member file for the ID keyed

Field Name: *DEACTIVATED RID*

Description – Member's RID number that is no longer active. Also called alias RID.

Format – 12 numeric characters

Features – None

Edits – 4003-ID must be 12 characters!

To Correct – Verify entry. The RID No. must be 12 characters

91056 - Please enter at least one search field.

To Correct – An entry is required in order to search for a member. Key in the RID NO or choose an alternative search option

91007 - Data must be numeric!

To Correct – Enter a 12 character numeric value

91024 - No match found for RID No.!

To Correct – Enter a valid RID No. There was not a match on the member file for the ID keyed

Other Messages

None

System Features

The **Search** button allows the user to search for the selected members. The **Exit** button allows the user to exit the Member Linking History window and return to the previous window.

System Information

PBL – RECIP03.PBL

Window – W_RE_LINK_XREF

Menu – M_BASE_LIST_SEARCH

Data Windows – DW_RE_LINK_XREF_DTE

DW_RE_LINK_XREF_SRCH

Glossary

1115(a)	Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts that are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by HCFA. See also *Health Care Financing Administration, PACE, Waiver*.
11971	State form 11971; see *8A.*
1261A	Division of Family and Children State Form 1261A, *Certification - Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility.*
1500	This is a claim form used by participating Medicaid providers to bill medical and medically related services.
1902(a)(1)	Section of the Social Security Act that requires state Medicaid programs be in effect "in all political subdivisions of the state". See also *Statewideness.*
1902(a)(10)	Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver*.
1902(a)(23)	Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver.*
1902(r)(2)	Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.
1903(m)	Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts*.
1915(b)	Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.
1915(c)	Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also *CLASS, HCS, MDCP, CMS, NF, Waiver.*
1915(c)(7)(b)	Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also *CMS, HCS-O, Waiver*.

1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also *Home and Community Care*.
450A	Social Evaluation for Long Term Care Admission.
450B	Certification by Physician for Long Term Care Services.
590 Program	A program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health.
7748	State Form 7748, Medicaid Financial Report.
8A	DPW Form 8A State Form 11971, *Notice to Provider of Member Deductible.* Used to relay member spenddown information to providers.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAP	American Academy of Pediatrics.
ABA	American Banking Association.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.
ACSW	Academy of Certified Social Worker.
ADA	American Dental Association.
ADC	Adult Day Care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.

Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children (AFDC) is replaced with Temporary Assistance for Needy Families (TANF).
AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance members, who are 65 years old or older, or members under any other category who are entitled to benefits under Medicare.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act.
Aid to the Blind (AB)	A classification or category of members eligible for benefits under the Medicaid Program.
AIM	Advanced Information Management.
allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.
alphanumeric	A field of numbers and letters.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.

Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
auto assignment	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning member eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.
Average Wholesale Price; used in reference to drug pricing.	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
AVR	Automated voice-response system used by providers to obtain pertinent information concerning member eligibility, benefit limitation, check information, and PA for IHCP participants.
AWP	Average wholesale price used for drug pricing.
banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavorial health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from HCFA regarding persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.

billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP member.
billing service	An entity under contract with a provider who prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
Blue Book	The *American Druggist Blue Book*, used as a reference in pricing drug products.
Boren Amendment	An amendment to *OBRA 80 (P.O. 96-499)*, which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
budgeted amount	The planned expenditures for a given time period.
bulletins	Informational directives sent to providers of Medicaid services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits/procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP members, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal, a document from the Indiana State Department of Health (ISDH) that certifies institutional providers.
C519	Authorization for Member Liability Deviation, generated by the Medicaid member's county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given member per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)

case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.
Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP member is eligible.
category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).
CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider who submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CDFC	County Division of Family and Children.
CEO	Chief Executive Officer.
certification	A review of CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM members to seek services from speciality providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services; health-care plan for the uniformed services outside the military health-care system, now know as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).

Children's Special Health Care Services(CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: HCFA-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.
claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for Medicaid claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP. See also *Member*.
CMHC	Community Mental Health Center.
CMS	Centers for Medicare & Medicaid Services. Effective August 2001, this is the new name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. It was formerly known as the Health Care Financing Administration for HCFA.
co-insurance	The portion of Medicare-determined allowed charge that a Medicare member is required to pay for a covered medical service after his/her deductible has been met. The co-insurance or a percentage amount is paid by Medicaid if the member is eligible for Medicaid. See also *Cost Sharing*.

Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also *ICF MR, 1915(c), Waiver*.
Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.
concurrent care	Multiple services rendered to the same patient during the same time period.
consent to sterilization	Form used by IHCP members certifying that they give "informed consent" for sterilization to be performed (it must be signed at least 30 days prior to sterilization).
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.
conversion factor	Number that when multiplied by a particular procedure code's relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
co-payment or co-pay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also *Cost Sharing*.
core contractor	Vendor that successfully bids *on Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services.*
COS	Category of Service.
cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.

cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.
county office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for IHCP using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP members.
CP	Clinical psychologist.
CPAS	Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.
CPS	Child Protective Services.
CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central processing unit.
CQM	Continuous quality management.
credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.
CRNA	Certified registered nurse anesthetist.
crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to Medicaid benefits).
CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.

CSHCS	Children's Special Health Care Services. A state-funded program providing assistance to children with chronic health problems. CSHCS members do not have to be IHCP-eligible. If they are also eligible for IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.
CSW	Clinical social worker.
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP, including state staff, members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
data element	A specific unit of information having a unique meaning.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
deductible	Fixed amount that a Medicare member must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug determined to be less than effective (LTE); not covered by the IHCP.
designee	Duly authorized representative of a person holding a superior position.
detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also *Mental Retardation, Related Condition.*
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through the CMS.
DHS	Department of Health Services.
diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also *ICD-9-CM, DRG*.
digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.
direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.

disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples include wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DOS	Date of service; the specific day services were rendered.
down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana agency overseeing agency compliance with all State data processing statutes, policies, and procedures.
DPOC	Data Processing Oversight Commission. Indiana agency providing oversight and review of all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Office of Medicaid Policy and Planning.
DPW Form 8A	See *8A*.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
drug code	Code established to identify a particular drug covered by the State Medicaid Program.
Drug Efficacy Study Implementation (DESI)	Listed drugs considered to be less than effective by the U.S. Food and Drug Administration. See also *Notice of Opportunity for Hearing (NOOH).*
drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series is usually associated with the reference, as well.
DSS	Decision Support System. A data extraction tool used to evaluate Medicaid data, trends, and so forth, for the purpose of making programmatic decisions.
dual eligible	A person enrolled in Medicare and Medicaid.
duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.

DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; primarily seen as LTC, long-term care; also seen as NH or NF.
ECM	Electronic claims management. Claims submitted in electronic format rather than paper. See *ECC, EMC*.
ECS	Electronic claims submittal. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDI	Electronic data interchange.
EDP	Electronic data processing.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
eligibility file	File containing individual records for all persons who are eligible or have been eligible for the IHCP.
eligible providers	Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.
eligible member	Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See *ECC, ECS*.
EMS	Emergency medical service.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's RA.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to members. The EOMB details the payment or denial of claims submitted by providers for services provided to members.
EOP	Explanation of payment. Describes the reimbursement activity on the provider's RA.

EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for Medicaid-eligible members under 21 years old, offering free preventive health care services, such as screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.
error code	Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
errors	Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also *Rejected Claim*.
ESRD	End-stage renal disease.
EST	Eastern Standard Time, which is also Indianapolis local time.
EVS	Eligibility Verification System. System used by providers to verify member eligibility using a point-of-sale device, online PC access, or an AVR system.
exclusions	Illnesses, injuries, or other conditions for which there are no benefits.
Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also *Preferred Provider Organization.*
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.
FAMIS	Family Assistance Management Information System.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also *Indemnity Insurance*.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.

field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
fiscal month	Monthly time interval in a fiscal year.
fiscal year	Twelve-month period between settlements of financial accounts.
fiscal year – federal	October 1 - September 30.
fiscal year – Indiana	July 1 - June 30.
flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.
FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, *Certification - Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*.
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.
FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
freedom of choice	A State must ensure that IHCP beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the Indiana Medicaid program.

FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.
Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as “paper” and “manual”.
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel.
HCFA	Health Care Financing Administration. This is the previous name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. Effective August 2001, it is called the Centers for Medicare & Medicaid Services.
HCFA-1500	HCFA-approved standardized claim form used to bill professional services.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	HCFA Common Procedure Coding System. A uniform health care procedural coding system approved for use by HCFA. HCPCS includes all subsequent editions and revisions.
header	Identification and summary information at the head (top) of a claim form or report.
HealthWatch	Indiana’s preventive care program for Medicaid members under 21 years of age. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
help	An online computer function designed to assist users when encountering difficulties entering a screen.

HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.
HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPP	Health insurance premium payments.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management.*
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also *Section 1919, Primary Home Care.*
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under Section *1915(c)(7)(b)* of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also *Section 1915(c)(7)(b), PASARR, Waiver.*
Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound members by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.

Hoosier Healthwise	IHCP managed-care program. Hoosier Healthwise has three components including Primary Care Case Management (PCCM), Risk-Based Managed Care (RBMC), and Managed Care for Persons with Disabilities (MCPD).
HPB	Health Professions Bureau.
HRI	Health-related items.
IAC	Indiana Administrative Code. State government agency administrative procedures.
IC	Indiana code.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for Medicaid-eligible, mentally retarded individuals.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.
IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.
IMCA	Indiana Motor Carrier Authority.
IMD	Institutions for mental disease.

IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.
IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also *Fee-for-Service*.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
inquiry	Type of online screen programmed to display rather than enter information. Used to research information about members, providers, claims adjustments and cash transactions.
institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPP	Individualized Program Plan.
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health. Currently known as the Indiana State Department of Health (ISDH).
ISDH	Indiana State Department of Health. Previously known as Indiana State Board of Health.
ISETS	Indiana Support Enforcement Tracking System.

ISMA	Indiana State Medical Association.
itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
LAN	Local area network.
LCL	Lower Control Limit (Pertaining to quality control charts).
licensed practical nurse	LPN.
limited license practitioner	LLP.
line item	A single procedure rendered to a member. A claim is made up for one or more line items for the same member.
LLP	Limited license practitioner.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
location	Location of the claim in the processing cycle such as paid, suspended, or denied.
lock-in	Restriction of a member to particular providers, determined as necessary by the State.
lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed practical nurse.
LSL	Lower specification limit, pertains to quality control charts.
LTC	Long term care. Facilities that supply long-term residential care to members.

LTE	Less than effective drugs.
M/M	Medicare/Medicaid.
MAC	Maximum allowable charge for drugs as specified by the federal government.
managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also *Section 1915(b), HMO, PPO, Primary Case Management.*
mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSDT (under age 21), medical transportation.
manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as *paper* and *hard copy*.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan*.
MCPD	Managed Care for Persons with Disabilities. One of three delivery systems in the Hoosier Healthwise managed care program. In MCPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
MDS	Minimum data set.
Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.
Medicaid certification	The determination of a member's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also *Medicaid State Plan, Single State Agency.*

Medicaid State plan	See also *Single State Agency, Medicaid Plan.*
Medicaid-Medicare eligible	Member who is eligible for benefits under both Medicaid and Medicare. Members in this category are *bought-in* for Part B coverage of the Medicare Program by the Medicaid Program.
medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the abscence of immediate medical attention could reasonable be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the state for the IHCP.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.
Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.
Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A and/or Part B for services authorized by Medicare Part A and/or Part B.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*.

mental retardation	Significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.
MFCU	Medicaid Fraud Control Unit.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral
misutilization	Any usage of the IHCP by any of its providers or members not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
MLOS	Mean Length of Stay.
MMDDYY	Format for a date to be reflected as month, day, and year such as 091599.
MMIS	Medicaid Management Information System. Indiana's current MMIS is Indiana*AIM*.
MOC	Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MRO	Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.
MRT	Medical Review Team. FSSA Unit that makes decisions regarding disability determination.
MSW	Master of Social Work.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NEC	Not elsewhere classified.

NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to online, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
NF	Nursing facility.
NH	Nursing home.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to *Service Packages #2 and #3*.
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the *Federal Register* on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also *Long Term Care, TILE.*
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also *Nursing Facilities, 1915(c), Waiver*.
OASDI	Old Age, Survivors and Disability Insurance. See also *Title II Benefits (Social Security or OASDI).*
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act. Federal laws that direct how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.
OMNI	Point-of-sale device used by providers to scan member ID cards to determine eligibility.

OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter (in reference to drugs).
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs Medicaid functions under the direction of the single state agency. The single state agency may perform all Medicaid functions itself or it may delegate certain functions to other processing agencies.
outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a Medicaid member from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a Medicaid member resulting from the failure of the contractor to use available information or to process correctly.
override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.

PA	Prior authorization. Some designated Medicaid services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by Medicaid.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by Medicaid that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as *hard copy* and *manual*.
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.
Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also *Medicare, Beneficiary*.
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also *Medicare, SMIB, Buy-In*.
participant	One who participates in the IHCP as either a provider or a member of services.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participating members	Individuals who receive Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the state that specifies the conditions and the services the facility must provide to serve Medicaid members and receive reimbursement for those services.
PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a member's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term-care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.

payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	Primary care case management. One of three delivery systems within the Hoosier Healthwise managed care program. Providers in PCCM are reimbursed on a fee-for-service basis. Members are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the member and providing all primary care and authorizing specialty care for the member—24 hours a day, seven days a week.
PCN	Primary care network.
PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.
peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.
PERS	Personal emergency response system, an electronic device that enables the consumer to secure help in an emergency.
personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also *Primary Home Care*.
PGA	Peer group average.
PHC	Primary home care. Medicaid-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional state plan benefit. See also *Personal Care*.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also *VISTA*.

physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.
plan of care	A formal plan developed to address the specific needs of an individual; links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to Medicaid members assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed **x** level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO)*.
PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.

prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.
procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also *Adjudicated Claim*.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities needed to meet all federal Pro-DUR requirements and all DUR requirements.
profile	Total view of an individual provider's charges or a total view of services rendered to a member.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that provides a covered IHCP service to an IHCP member.
provider enrollment application	Required document for all providers who provide services to IHCP members.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.
provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor, dentist.
PSRO	Professional standards review organization.

purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RBA	Room and board assistance.
RBMC	Risk-based managed care. One of three delivery systems in the Hoosier Healthwise managed care program. In RBMC, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. The delivery system serves TANF members, pregnant women, and children.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by OMPP.

reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
member	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP members. These individuals are called enrollees or members when in the Hoosier Healthwise Progam. See also *Client, Eligible Member*.
member relations	The activity within the single state agency that handles all relationships between the IHCP and individual members.
member restriction	A limitation or review status placed on a member that limits or controls access to the IHCP to a greater extent than for other nonrestricted members.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a member to another provider for treatment service.
regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.
reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also *Stop-Loss Insurance*.
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the member disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.

rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.
repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Restrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Rural health clinic.
RID	Member identification (ID) number; the unique number assigned to an individual who is eligible for Medical Assistance Programs services.
risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also *MCO, Pool, Risk Pool*.
RN	Registered nurse.
RNC	Registered nurse clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment
RPT	Registered physical therapist.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
SBOH	State Board of Health. Previous term for the State Department of Health.

screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
selective contracting	Option under Section *1915(b)* of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.
service date	Actual date on which a service(s) was rendered to a particular member by a particular provider.
service limits	Maximum number of service units to which a member is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with an MCO's health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Omnibus Budget Reconciliation Act of 1986.
SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.

specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
spenddown	Process whereby Medicaid eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.
SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.
SSP	State Supplement Program. State-funded program providing cash asssistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor
Staff Model HMO	Health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.
State	The state of Indiana and any of its departments, agencies, and public agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.

State Medicaid Office	Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the Medicaid program in Indiana.
State Plan	The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.
status	Condition of a claim at a given time; such as paid, pended, denied, and so forth.
stop-loss insurance	Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125% of the amount expected in an average year. See also *Reinsurance*.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.
submission	The act of a provider sending billings to EDS for payment.
subsystem	A Medicaid term that refers to one of the following (I)HIS processing components: member's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.
SUR	Surveillance and Utilization Review. Refers to system functions and activities mandated by the CMS that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements: l analysis ı processing and member profiles tive detection of claims processing edit/audit failures/errors tive detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards tive detection of fraud and abuse by providers or members ated data and claim analysis including sampling and reporting ccess and processing features eports and output
suspended transaction	A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s).
suspense file	Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s).

systems analyst/engineer	Responsible for performing the following activities: system/program design rogram development nce and modification analysis/resolution ds analysis ning support nent of personal Medicaid program knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.
TEFRA 134(a)	Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children.
therapeutic classification	Code assigned to a group of drugs that possess similar therapeutic qualities.
third party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or member of, medical assistance under Title XIX.
third-party resource	A resource available, other than from the department, to an eligible member for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.
Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.
Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.

Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all members to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirments of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the members to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.
TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services.*
TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.
UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.
UPC	Universal product code. Codes contained on the first data bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization review.

UR	Utilization Review. A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.
utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VFC	Vaccines for Children program.
VFC	Vaccine for Children program.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under 5 years old.
workmen's compensation	A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.

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